

Dissertation submitted in accordance with the requirements for the degree of Doctor of Philosophy

The Transformation of the Turkish Welfare State

Conceptualizing the Role of the State, the Market, Non-governmental Actors, and the Family in
Healthcare Financing, Provision, and Regulation

by Daniel Grütjen

Freie Universität Berlin

Department of Political and Social Sciences

Date of disputation: 4 May 2017

First supervisor: Prof. Dr. Barbara Riedmüller

Second supervisor: Prof. Dr. Cilja Harders

Table of contents

List of figures and tables	v
List of abbreviations	vi
Acknowledgments.....	vii
Preface.....	viii
Introduction	1
I. Analytical framework.....	10
1. Theoretical framework.....	11
1.1 Structuralist approaches	13
1.2 Power resource approaches and the focus on groups in society	16
1.3 Institutional approaches	18
1.4 Governance approaches and the transformation of state action	21
1.5 Regime approaches	24
1.6 Feminist approaches	30
1.7 Interim results	34
2. Historical institutional framework.....	36
2.1 The Ottoman legacy – The inception of state dominance over healthcare provision.....	36
2.2 The early years of the Republic – Health policy as a means for nation building and modernization (1923-1950).....	40
2.3 The rise of Turkey’s democracy (1950-1960) – The state emerges as a provider of curative care	45
2.4 Contested national developmentalism – The establishment of a two-tier healthcare system (1960-1980)	48
2.5 Liberal conservatism and the rise of healthcare markets (1980 to 2002).....	52
2.6 The rise of the AKP and the reform of the Turkish healthcare system	58
2.7 Interim results	61
3. Classification of the Turkish healthcare system.....	64
3.1 Financing procedures	66
3.2 Eligibility criteria	69
3.3 Benefit provision.....	71
3.4 Reimbursement procedures.....	74
3.5 Organization and development of the delivery system	77
3.6 Interim results	79
4. Research design.....	81
4.1 Theoretical approach, research questions, and hypotheses	81
4.2 Analytical framework and methodology	83
II. The Turkish healthcare system in transformation	90
5. The transformation of healthcare financing.....	91

5.1 Healthcare expenditure	91
5.1.1 Changes in the level of healthcare expenditure	92
5.1.2 Changes in the structure of healthcare expenditure	93
5.2 Healthcare financing	99
5.2.1 Healthcare financing prior to the HTP	100
5.2.2 Healthcare financing since the implementation of the HTP.....	111
5.3 Intermediate results: The transformation of healthcare financing	120
6. The transformation of healthcare provision.....	126
6.1 Curative care	128
6.1.1 The transformation of inpatient curative care	128
6.1.2 The transformation of day care	133
6.1.3 The transformation of outpatient care	133
6.1.4 The transformation of home care	137
6.2 Rehabilitative care	139
6.3 Long-term care	142
6.4 Medical goods	145
6.5 Preventive care	146
6.6 Intermediate results: The transformation of healthcare provision	148
7. The transformation of healthcare regulation	154
7.1 Regulation of the relationship between financing agents and patients	155
7.1.1 Regulation of the relationship between financing agents and patients prior to the HTP	156
7.1.2 Regulation of the relationship between financing agents and patients since the HTP	162
7.2 Regulation of the relationship between financing agents and providers	168
7.2.1 Regulation of the relationship between financing agents and providers prior to the HTP	168
7.2.2 Regulation of the relationship between financing agents and service providers since the	174
HTP	
7.3 Regulation of the relationship between providers and patients.....	179
7.3.1 Regulation of the relationship between service providers and patients before the HTP .	179
7.3.2 Regulation of the relationship between service providers and patients since the HTP ...	182
7.4 Intermediate results: The transformation of healthcare regulation	184
8. The Turkish healthcare system under AKP governance	191
III. Conclusion	195
Bibliography	200
Appendix I: Summary of findings	I
Appendix II: Kurzfassung der Ergebnisse	V

List of figures and tables

Figure 1	Types of healthcare systems by provision and funding.....	65
Figure 2	Current expenditure on healthcare by financing scheme as percentage of total expenditure in Turkey, years 1990 to 2014.....	68
Figure 3	Current expenditure on healthcare by function, year 2000 or closest year available.....	95
Table 1	Current expenditure on healthcare by financing scheme as percentage of total expenditure, early 1990s.....	67
Table 2	Current expenditure on healthcare by financing scheme as percentage of total expenditure, year 2003.....	67
Table 3	Current expenditure on healthcare by financing scheme as percentage of total expenditure, year 2014.....	67
Table 4	Coverage of healthcare systems as a percentage of the population.....	70
Table 5	Predominant mode of healthcare entitlement.....	70
Table 6	Cost sharing for outpatient care.....	72
Table 7	Cost sharing for pharmaceuticals.....	72
Table 8	Ownership of hospitals.....	74
Table 9	Predominant mode of healthcare remuneration.....	76
Table 10	Authority to open new hospitals.....	78
Table 11	Types of healthcare systems.....	84
Table 12	Total current expenditure on health as a percentage of GDP.....	92
Table 13	Total health expenditure per capita in U.S. dollars, constant prices, constant PPPs, OECD base year, 1970-2015.....	93
Table 14	Health expenditure in Turkey by function as a percentage of total expenditure on health, years 2000 to 2012.....	94
Table 15	Current healthcare expenditure by financing agent as a percentage, year 2000.....	96
Table 16	Healthcare Financing Schemes in Turkey, year 2003.....	121
Table 17	Healthcare Financing Schemes in Turkey, year 2014.....	121
Table 18	Ownership of hospitals and hospital beds as a percentage, years 2000 and 2013.....	129
Table 19	The transformation of the actor constellation in healthcare provision.....	149
Table 20	Overview of policy instruments.....	155
Table 21	Changes in the regulation of the relationship between financing agents and patients, years 2003 and 2014.....	185
Table 22	Changes in the regulation of the relationship between financing agents and providers, years 2003 and 2014.....	187
Table 23	Changes in the regulation of the relationship between providers and patients, years 2003 and 2014.....	189

List of abbreviations

AKP	Justice and Development Party (<i>Adalet ve Kalkınma Partisi</i>)
ANAP	Motherland Party (<i>Anavatan Partisi</i>)
AP	Justice Party (<i>Adalet Partisi</i>)
Bağ-Kur	Social Insurance Agency for Craftsmen, Tradesmen, and other Self-Employed (<i>Esnaf ve Sanatkârlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu</i>)
CHP	Republican People's Party (<i>Cumhuriyet Halk Partisi</i>)
DP	Democratic Party (<i>Demokrat Parti</i>)
DRG	Diagnosis-related group
EU	European Union
GDP	Gross domestic product
HTP	Health Transformation Program (<i>Sağlıkta Dönüşüm Programı</i>)
IMF	International Monetary Fund
ISI	Import Substitution Industrialization
İSK	Labor Insurance Institution (<i>İşçi Sigortaları Kurumu</i>)
MHP	Nationalist Movement Party (<i>Milliyetçi Hareket Partisi</i>)
MNP	National Order Party (<i>Milli Nizam Partisi</i>)
MoF	Ministry of Finance (<i>Maliye Bakanlığı</i>)
MoH	Ministry of Health (<i>Sağlık Bakanlığı</i>)
NHS	National Health Service
OECD	Organization for Economic Co-operation and Development
PKK	Kurdistan Workers' Party (<i>Partiya Karkerên Kurdistanê</i>)
PPP	Purchasing power parity
RP	Welfare Party (<i>Refah Partisi</i>)
SGK	Social Security Institution (<i>Sosyal Güvenlik Kurumu</i>)
SHA	System of Health Accounts
SHÇEK	Agency for Social Services and Child Protection (<i>Sosyal Hizmetler ve Çocuk Esirgeme Kurumu</i>)
SSK	Social Insurance Agency (<i>Sosyal Sigortalar Kurumu</i>)
TurkStat	Turkish Statistical Institute (<i>Türkiye İstatistik Kurumu</i>)
UK	United Kingdom
UNECE	United Nations Economic Commission for Europe
US	United States
USA	United States of America
WHO	World Health Organization

Acknowledgments

I would like to express my deepest and sincere gratitude to my supervisors Professor Barbara Riedmüller and Professor Cilja Harders. It was Professor Riedmüller who gave me the initial impulse to write this thesis and I am deeply thankful for her valuable and constructive criticism throughout the entire process.

This thesis would also not have been possible without the invaluable support of my friend and mentor Professor Kerem Öktem. Our conversations about Turkish politics and his constructive advice regarding the structure and main arguments have helped shaped the outcome of my work.

I, and the readers of this thesis, owe thanks to my dear friend Jonathon Burch whose meticulous editing has improved the final version of this thesis significantly.

Finally, and most importantly, I would like to express my gratitude and apologies to my wife Dilan Köseler Grütjen and our daughters Lia and Lena. In addition to my full-time job, I have spent countless hours researching and writing on gendered social policies and the role of the family in healthcare, all the while neglecting my own family. By caring for our daughters, my wife gave me the time and space to finalize this project and I am truly indebted to her.

Preface

Our daughter Lia was born on January 5, 2010 in a private hospital in Istanbul's Fatih district. Although I had already been living in Turkey for several years, her birth was my first significant encounter with the Turkish healthcare system. Lia, like approximately half of all newborns in Turkey, was delivered by caesarean section. My mother-in-law and I spent the night after her birth on pull-out visitor beds next to my wife. We were issued cards identifying us as *refakatçi* (companion). This status allowed us to stay overnight with my wife and enter the hospital outside visiting hours.

After a medical examination by the physician and brief instructions by the midwife, my wife and Lia were discharged the following day. I can still recall clearly how the midwife had addressed my mother-in-law, putting her as the experienced mother in charge of my wife's and daughter's well-being.

That night, Lia suddenly ran a high fever and I had to rush her back to the hospital. She had become severely dehydrated and was given formula milk to drink, after which her temperature quickly came down. Nevertheless, the doctor decided to keep her under observation and she was placed in an incubator in the intensive care unit. The nurse instructed me to bring milk powder, diapers, and medication from a nearby pharmacy. Lia was finally discharged five days later.

Looking back, this experience was to become a decisive factor in my desire to conduct research into the Turkish welfare state, with a specific focus on the mechanisms through which family members are engaged in healthcare. In this thesis, I show how the experience of Lia's birth contains several aspects that exemplify how patients' family members interact with the various governmental and non-governmental actors of the Turkish healthcare system. For example, the common practice in state-owned hospitals of making relatives pay for medical goods out-of-pocket is one of the numerous ways in which households contribute to healthcare financing in Turkey. Furthermore, patients receiving treatment in hospital have the legal right to be accompanied by a relative who, in practice, is also commonly delegated medical care duties by healthcare professionals. Most importantly, the perception that my mother-in-law was responsible for my wife's and daughter's health appears emblematic of a healthcare system in which postnatal and long-term medical care are almost entirely provided by female relatives in the home.

Introduction

Since the 1980s, Turkey has undergone substantial social, economic, and political transformations. The most recent of these are the direct result of the political reforms of the ruling Justice and Development Party (*Adalet ve Kalkınma Partisi*), hereafter referred to as AKP. These reforms have not only reshuffled power relations between institutions, actors, and elites, but have also brought about widespread economic development that has benefited broad segments of society across the entire country. Until the beginning of this decade, these reforms also allowed Turkey to present itself as a viable and important actor in the region.

More recently, however, and especially since the anti-government Gezi protests of 2013, authoritarianism and increasing societal polarization recall darker moments in the country's troubled history. The AKP government has impaired fundamental freedoms and further dismantled an already weak system of checks and balances. Political power has been concentrated at the executive level which, today, is under the control of President Recep Tayyip Erdoğan. Once perceived as a model country that accommodated Islam, liberal values, and capitalism, many observers now see Turkey's transformation toward a totalitarian regime inevitable following an escalation of illiberal governance under the AKP (Öktem 2016; Gürsel 2016; Tuğal 2016).

Despite this trend, popular support for the AKP and President Erdoğan remains high. In the last parliamentary election held in November 2016, the AKP secured 49.5 percent of the vote, which resulted in an overall majority of 317 parliamentary seats out of a total 550. This continued and enthusiastic support for the AKP by a large section of the population has puzzled many observers, who tend to dismiss the party's success as the result of a mixture of authoritarian politics, a symbiosis of nationalist and religious rhetoric, and societal polarization.

These explanations, however, often neglect the fact that the AKP government has implemented key policies to the benefit of large segments of society that had previously been excluded from public services. A prime example is the reforms that led to the transformation of the Turkish healthcare system.

Prior to the series of reforms launched by the AKP in 2003 as part of the Health Transformation Program (*Sağlıkta Dönüşüm Programı*), hereafter referred to as HTP, Turkey's healthcare system was indicative of the country's underdeveloped welfare state. A large percentage of the population was excluded from public health insurance. Levels of inequality in access to services across different occupational and social groups were high. Furthermore, a general reluctance by the state to engage in welfare provision meant that many Turks relied on their family's means and readiness to finance and provide healthcare.

The implementation of the HTP appears to have fundamentally changed this picture. Between 2003 and 2014, the share of the population covered by public health insurance increased from 71.6 percent to 98.4 percent (OECD Health Statistics 2016). The highly fragmented social insurance system of earlier years was centralized under the roof of the newly established Social Security Institution (*Sosyal Güvenlik Kurumu*), hereafter referred to as SGK, which today ensures equal rights and benefits for all insurants. At the same time, healthcare provision was reorganized, leading to better access and higher quality services.¹ These outcomes of the AKP reforms point to a fundamental shift in the role of the state in the Turkish healthcare system and to the emergence of a mature welfare state concerned with protecting its citizens from risks on the basis of social rights.

However, a number of studies have argued that the AKP reforms simply form part of a larger neo-liberal project, and are, therefore, purely symptomatic of the economic and political transformation of the country.² They point to the dramatic increase in the number of for-profit healthcare providers. Since the launch of the HTP, the share of private hospital beds has almost doubled to approximately one-third of all hospital beds and the share of patients who seek inpatient treatment in private hospitals has tripled to 30 percent (MoH 2014, 71).

These developments raise a number of research questions on the nature and scope of recent changes in healthcare policy and politics: What has changed in healthcare policy since the AKP came to power? How profound are these changes? How do they affect the actor constellation of the Turkish healthcare system? Do policy changes imply a new role of the state in healthcare and welfare provision? Has a new type of modern healthcare system emerged in Turkey different from its counterparts in Europe? How do changes in healthcare policy and politics under the AKP relate to the general transformation of political institutions in Turkey?

This thesis comprises an analysis of the political institutions and actors involved in healthcare policy in Turkey. Its conceptual framework elaborates on theoretical and methodological approaches that bridge the gap between welfare state and healthcare system analysis. This framework demonstrates that in the realm of healthcare, legal and organizational features of the state, the market, civil society, and the family are systematically interwoven. At the same time, it conceptualizes changes in healthcare policy and the Turkish healthcare system, defined as the actor constellation that finances, provides, and regulates healthcare.

¹ For an overview of the HTP reforms see: Barış et al. 2011; OECD and World Bank 2008, 50-53; OECD 2014, 33-114; Tatar et al. 2011, 113-46.

² For critical analyses of the HTP reforms see: Aykan and Güvenç Salgırlıa 2015; Etiler 2011; Terzioğlu 2016; Yılmaz 2013, 74-75.

Based on this framework, I present the following main hypothesis: The political hegemony of the AKP government constitutes a critical juncture, which has led to a paradigm shift in healthcare policy and a system change in the actor constellation that constitutes the healthcare system of contemporary Turkey.

The argument

The key findings of my dissertation can be summarized as follows: First, I argue that under AKP governance Turkey's healthcare system has undergone a paradigm shift. Prior to recent reforms, there was no consistent healthcare policy in Turkey and coverage of the healthcare system was highly selective. With the rise of the AKP a new policy paradigm has gained momentum: the establishment of a healthcare system that provides universal coverage. I argue that, underpinned by this objective, the healthcare reforms of the AKP have led to the emergence of a mature welfare state that protects its citizens from health-related risks on the basis of social rights.

My second assertion is that with regard to the role of the state in healthcare regulation, the reforms have been path-dependent. The predominant mode of governance under the AKP is marked by a state that intervenes in society and the economy in a hierarchical manner. I show that this perception of statehood has been a characteristic of the Turkish healthcare system since the late Ottoman Empire and sets Turkey apart from the healthcare systems of corporatist welfare states, in which healthcare governance is dominated by autonomous non-governmental actors. I furthermore contend that this institutional trait reflects the predominant perception of statehood in Turkish society as a whole.

Third, I argue that the reforms of the AKP are based on a highly gendered provision of healthcare. I demonstrate how the Turkish healthcare system has traditionally been underpinned by the principle that the family is foremost responsible for the financing and provision of the healthcare of its members. However, policymakers did little to support Turkish families in this assumed role. In contrast, the reforms of the AKP aim at strengthening the family's capacity to finance and provide healthcare to its individual members and, at the same time, formalizing and further institutionalizing the role of the family in healthcare financing and provision. Based on these findings I conclude that the healthcare policy reforms of the AKP reproduce existing gender roles and that the establishment of universal coverage has had significantly gendered effects, which reduce the autonomy of women.

With this thesis I make a theoretical and empirical contribution to two relatively unexplored fields of social science: first, Turkish social policy and, second, the relationship between healthcare systems and welfare states. Contrary to the scholarship on the political and economic reforms of the AKP

government, the academic debate on the country's social policies is still in its infancy.³ The reasons for the lack of academic interest in the Turkish welfare state are manifold. An absence of reliable data from Turkey makes it difficult to include the country in any comparative analysis. Furthermore, welfare state analysis has only recently begun to overcome its Eurocentric focus (Castles et al. 2010, 2). Located on Europe's geographic and economic periphery, one could assume that Turkey provides little insight into the workings of the mature welfare states of Western and Northern Europe. At the same time, Turkey is commonly neither perceived as part of Southern Europe nor the Arab world and is, therefore, excluded from most comparative studies focusing on these regions.⁴

While the contribution of this study to mainstream research on Turkey may at first seem limited, closer scrutiny reveals that an analysis of the state's role in welfare provision offers great insight into state-society relations in Turkey and into the prevalent perception of statehood and citizenship.

Welfare state analysis and the case of the Turkish healthcare system

Comparative welfare state analysis focuses on cross-national variations of institutionalized forms of social protection that secure citizens on the basis of social rights and of their impact on social relations (Esping-Andersen 1990, 18-26). As Thomas H. Marshall argues, it was the entitlement to social rights, in addition to the guarantee of legal and political rights, which shaped the development of modern citizenship (Marshall 1950, 12-13). Similarly, Amartya Sen stresses the importance of the level at which welfare policies increase the individual's capability to participate in society and to live what they consider a good life that is essential for human development (Sen 1999, 70-71). Additionally, a number of scholars argue that welfare state institutions are shaped by competing ethic values, such as the satisfaction of basic needs, the creation of equality among citizens, or the liberty necessary for individual self-empowerment. These values derive from prevailing political ideologies underpinning state institutions, such as corporatism, social democracy, or liberalism. A paradigm shift in the arena of the welfare state, therefore, indicates changes in society's predominant perception of statehood and citizenship (Esping-Andersen 2002, 2). Closely related to this argument, welfare state analysis makes a significant contribution to the ongoing debate on the transformation of modern nation states and shows how new forms of governance structure social relations in industrialized societies (Majone 1997; Schuppert 2008). Accordingly, this study is based on the premise that an analysis of the

³ Numerous studies focus on the democratization and trajectory of political and social developments in Turkey. See for example: Keyman and Öniş 2007; Öktem 2011; Yavuz 2006; White 2014. Much scholarship also focuses on the transformation of Turkey's foreign policy such as the following studies: Müftüler-Baç and Stivachtis 2008; Müftüler-Baç 2011; Öktem et al. 2012, as well as the country's remarkable economic performance over the last decade including the studies by: Öniş 2006; Öniş and Güven 2011; Buğra and Savaşkan 2014.

⁴ Exceptions are: Buğra and Keyder 2006; Gough 1996; Grütjen 2008; Jawad and Yakut-Çakar 2010; Saraceno 2002.

transformation of the Turkish healthcare system enhances our understanding of the general trajectory of democracy and society in Turkey.

In addition to examining Turkish social policy, this thesis aims to enhance our understanding of the relationship between healthcare systems and welfare states. Health is a major concern for individuals and societies and a key factor in human development. Healthcare, as a labor market and an arena of industrial innovation and investment, is an integral part of capitalist economies. The formation of institutions that regulate access to, finance, and provide healthcare, has been closely linked to the emergence of modern nation states. Healthcare policies, therefore, not only affect the sick alone but a multitude of public and private actors and institutions.

Michael Moran argues that “[m]aking sense of what is happening to the healthcare state is critical to making sense of what is happening to modern welfare states” (Moran 2000, 139). To date, however, comparative welfare state analysis has largely overlooked the field of healthcare. Dominant theoretical and methodological tools, developed to investigate the origins and workings of welfare states, seem to come unstuck when applied to healthcare systems. Furthermore, welfare state typologies are often mismatched with those of healthcare systems (Alber 1995; Kasza 2002).

Only recently have a number of studies shown that the theoretical and methodological approaches of comparative welfare state research provide a suitable framework for analyzing the political and socio-economic embeddings in healthcare systems.⁵ By focusing on the Turkish case, this study aims to make a contribution to this literature.

Paul Pierson highlights that analysis of different real types of welfare states has brought new perspectives on the workings of welfare states in general and has enhanced existing theoretical models of welfare state analysis. He stresses that “[j]ust as focus on Sweden was central for the development of the power resources model, concentration on the United States has underscored the importance of political institutions” (Pierson 1996, 152).

My assertion is that an examination of the Turkish case highlights a shortcoming in the academic literature which, to date, has largely neglected the family’s role in healthcare systems. Accordingly, this thesis aims to enhance our understanding of the changing role of the family in healthcare financing and provision. Furthermore, it examines how this role has been strengthened and reproduced by public policies. Focusing on the family’s role in the Turkish healthcare system may also enhance our understanding of the family’s role in healthcare in the welfare states of Western and Northern Europe. A number of recent studies point to a refamilialization of welfare in industrialized countries (Blome et al. 2009, 16). In the realm of healthcare, this trend is reflected in the ongoing debate over to what

⁵ See in particular: Marmor et al. 2005; Moran 1999; 2000; Wendt 2005; 2009; Wendt et al. 2009.

degree inpatient curative and long-term care may be substituted by home care in order to reduce hospitalization periods (Kollak 2001; von Reibnitz and Hagemeyer 2005).

Simultaneously, the analysis of the transformation of the role of the family in the Turkish healthcare system also helps us understand its transformation in Turkish society as a whole. The family in Turkey has a much greater function than simply a provider of welfare. Its cultural, economic, and social importance is omnipresent and has become an integral part of the country's version of modernity and capitalist economy (Duben 2013; Kalaycıoğlu and Rittersberger-Tılıç 2000).

This thesis is not a comparative analysis of the Turkish healthcare system. However, the hypotheses which structure my analysis are informed by the theoretical approaches of comparative welfare state analysis. Furthermore, I use data from other healthcare systems as a reference to highlight the characteristics of the Turkish case. While the thesis never completely loses its comparative angle, it is important to highlight that the main points of reference are theoretical and empirical findings from mature welfare states. There are two main arguments as to why I neglect the academic debate on data from late-industrializing welfare states, despite Turkey being a late industrializing middle-income country: First, taking welfare states in the industrialized world as a reference allows me to show that in the realm of healthcare, a mature welfare state has emerged in Turkey. Second, it allows me to substantiate my argument that the examination of the Turkish case highlights a shortcoming in the academic literature on mature welfare states which, to date, has largely neglected the family's role in healthcare systems.

Structure of the thesis

This thesis is structured into three parts with the first part outlining the analytical framework. The first chapter discusses the key approaches of welfare state analysis, including their reception in healthcare system analysis, based on their capacity to guide analysis of the political institutions and actors in healthcare policy in Turkey. In particular, I consider two approaches as insightful: the historical institutionalist approach and the regime approach. The historical institutionalist approach offers a comprehensive framework for the analysis of institutional changes under the AKP government, by putting them into context with the long-term transformation of healthcare institutions in Turkey. It explains why established healthcare institutions change at a certain point in time and conceptualizes linkages between the AKP's healthcare reforms and the broader political and socio-economic context. The regime approach, complemented by the findings of governance and feminist approaches, offers a comprehensive theoretical and methodological framework for the analysis of the transformation of healthcare policy and the actor constellation that constitutes the Turkish healthcare system. It stresses changes in the institutional links between the state, the market, non-governmental actors, and the

family, in the realm of healthcare, as well as the ideological underpinnings of these institutional arrangements (Esping-Andersen 1990; Wendt 2009).

In the second chapter, I delineate the historical institutional framework of this study. Based on literature review, I examine the emergence and transformation of modern welfare and healthcare institutions in Turkey. Guided by the historical institutionalist approach, I argue that any analysis of the current transformation of Turkey's healthcare system must be informed by a cautious reading of history and comprehensive empirical knowledge of its historical origins and institutionalization. The key findings of this chapter are that the design of modern healthcare institutions in Turkey was based on the leitmotif of hierarchical state control and that the modernization of healthcare institutions during the history of the Turkish Republic has been characterized by a high level of path dependency. At the same time, I show that in light of the absence of societal and structural pressures, the state only reluctantly engaged in the realm of healthcare. However, my findings also suggest a comprehensive transformation of the Turkish healthcare system under AKP governance.

In order to shed light on the key characteristics of the Turkish healthcare system and the trajectory of its transformation, Chapter 3 comprises its classification according to the groundbreaking typology of healthcare systems developed by George J. Schieber for the Organization for Economic Co-operation and Development, hereafter referred to as OECD (OECD 1987). My findings indicate a maturing of the Turkish welfare state in that it has established institutionalized forms of social security that aim at the protection of all citizens from social risks on the basis of rights. However, I also find that the healthcare system in Turkey continues to differ from its mature counterparts in particular with regard to the role of the family in healthcare financing and the strict regulation by the state of healthcare providers.

Based on the findings of the first three chapters, Chapter 4 outlines the research design of the analysis of the changing role of political institutions and actors in healthcare policy. It delineates the theoretical approach, which is based on historical institutionalism and the regime approach. Furthermore, Chapter 4 presents the hypotheses and introduces a new analytical framework, which elaborates on the conceptualizations of policy change developed by Peter Hall and healthcare system change developed by Claus Wendt et al. (Hall 1993; Wendt et al. 2009).

The second part comprises the heart of this study. In four chapters, I discuss the hypotheses of this thesis and examine how healthcare policies and the actor constellation that constitutes the Turkish healthcare system have changed since the rise of the AKP. In order to ensure the comparability of its findings and the systematic analysis of the transformation of the Turkish healthcare system over time, concepts and indicators used by the System of Health Accounts 2011, hereafter referred to as SHA 2011, which were co-developed by the OECD, Eurostat, and the World Health Organization (WHO), will be integrated into the analytical framework (OECD et al. 2011; OECD and WHO 2014).

In the fifth chapter, I analyze the transformation of the Turkish healthcare system in terms of how it is financed. The chapter comprises two sections. In the first section, I look at the levels and functional distribution of healthcare expenditure in Turkey based on key indicators employed by the SHA 2011. Complementary to the findings of Chapter 3, I reveal key characteristics of healthcare financing and the trajectory of its transformation over the past few decades.

Elaborating on these findings, I highlight healthcare policy changes in the second section, as well as shifts in the actor constellation concerning the financing of Turkey's healthcare system. Essential for my analysis is the analytical concept of financing schemes, which have been introduced by the SHA 2011 to describe the institutional structure of different health financing systems (Ibid., 7). Based on the examination of key legislation and the secondary analysis of statistical data, as well as the relevant academic literature, I analyze how the constellation of the state, the market, non-governmental actors, and the family in the existing healthcare schemes has changed since the AKP came to power. I also examine shifts in the hierarchy of policy goals that structure the Turkish healthcare system.

In Chapter 6, I analyze policy change and shifts in the actor constellation within the provision dimension of Turkey's healthcare system. The analysis is structured by categories of healthcare functions and providers defined by the SHA 2011. In order to categorize healthcare providers, I use ownership and profit-orientation as key indicators. The chapter is based on the analysis of key legislation, expert interviews, and the secondary analysis of statistical data, as well as the relevant academic literature.

In Chapter 7, I provide an analysis of the transformation of the regulation of healthcare financing and provision in Turkey. Based on Wendt et al., three levels of healthcare governance are examined: (i) the relationship between patients and financing agents; (ii) the relationship between financing agents and service providers; and (iii) the relationship between patients and service providers (Wendt et al. 2009, 80). On each of these levels three questions will be examined: who is in charge of regulating and controlling these relationships? What is the goal behind the regulation of these relationships? Which policy instruments are used to regulate these relationships? Methodologically, this chapter is based on the analysis of key legislation and secondary literature analysis.

In Chapter 8, I summarize the findings of the analysis of the three dimensions of the Turkish healthcare system and discuss the validity of the hypotheses. The main hypothesis is considered valid if we can observe a paradigm change in healthcare policies, defined as a radical alteration in the hierarchy of policy goals, and a system change in healthcare politics, defined as an alteration in the healthcare system's predominant actor.

The third part serves as the conclusion in which I put the developments within healthcare policy into context with the overall transformation of Turkish politics and society, and discuss the relevance of my findings for the academic debate on the transformation of welfare states.

In sum, this thesis aims to enhance understanding of the institutional transformation of the Turkish welfare state by focusing on changes in healthcare policies and the actor constellation that constitutes the country's healthcare system. The empirical focus of this study is the Turkish case, however, its theoretical and empirical findings may serve as a starting point for comparative research. Its rapid political and socio-economic transformation makes Turkey a relevant case for research on welfare reforms in emerging countries. In addition, I claim that comparative analysis of the Turkish welfare state with its distinctive path of modernization, as well as a particular focus on the transformation of the inherent role of the family, will shed light on the workings of welfare states in general and enhance understanding of welfare arrangements in Western and Northern Europe and beyond.

I. Analytical framework

In this part, I develop the analytical framework of the study. In Chapter 1, I discuss the key theoretical approaches that guide the scholarly debate on welfare and healthcare systems and their capacity to analyze changes in healthcare policy, as well as the actor constellation of the Turkish healthcare system. In particular, I show that the historical institutionalist approach and the regime approach guide my inquiry. In Chapter 2, I provide a historical analysis of the emergence of those state and healthcare institutions that shape the contemporary actor arrangements of the Turkish healthcare system. In Chapter 3, I identify the key characteristics of the transformation of the Turkish healthcare system through its classification in the most prominent typology of healthcare systems developed by George J. Schieber for the OECD. Based on the findings of the first three chapters, I present in Chapter 4, the theoretical approach, analytical framework, and methodology that I have employed to examine the main hypothesis that the political hegemony of the AKP government constitutes a critical juncture, which has led to a paradigm shift in healthcare policy and a system change in the actor constellation that constitutes the healthcare system of contemporary Turkey.

1. Theoretical framework

Contemporary studies on welfare states can rely on a rich history of social policy analysis. Existing methods and theoretical approaches in the field provide us with effective tools to investigate the emergence, transformation, and functioning of welfare states. Laying at the intersection of the relationship between the state and the market, welfare provision has been a primary focus of the different schools of political economy decades before the welfare state even came into existence. Contemporary definitions of key variables in welfare state analysis such as state, market, class, and democracy, as well as conclusions about their interrelation have, therefore, been significantly shaped by Liberal, Conservative, and Marxist understandings of society. Accordingly, the main questions surrounding welfare state research have not changed in the course of the last two centuries: Which powers underpin the welfare state and its transformation? Is an individual's position in society altered by social programs? Under which conditions can social inequalities produced by capitalism be undone by democracy (Esping-Andersen 1990, 9-21)? Nevertheless, as Gøsta Esping-Andersen points out, the motivation for modern scholarship on the welfare state significantly differs from that of its theoretical forebears:

Contemporary social science distinguishes itself from classical political economy on two scientifically vital fronts. First, it defines itself as a positive science and shies away from normative description (Robbins, 1976). Second, classical political economists had little interest in historical variability: they saw their efforts as leading towards a system of universal laws. Although contemporary political economy sometimes clings to the belief in absolute truths, the comparative and historical method that today underpins almost all good political economy is one that reveals variation and permeability (Ibid., 12).

First cross-national comparisons of social protection systems can be traced back to the 1950s and 1960s. During this period of welfare state growth in western and northern Europe, functionalist approaches gained popularity, which explained the emergence of modern welfare states as a consequence of economic development and anticipated a convergent evolution of social security systems. While this assumption was challenged by the subsequent era of welfare austerity in the aftermath of the oil price shocks of the 1970s and the erosion of the Fordist production model, theoretical concepts such as power resource approaches—focusing on the influence of organized interest groups—and institutionalist approaches—focusing on the impact of institutions on policy making—have offered insightful explanations for divergent trajectories in welfare state development. These early comparative studies have focused on the questions “when and why democratic processes result in an extension of social rights?” (Immergut 1992, 2).

Esping-Andersen's claim in the early 1990s that welfare states in industrialized countries cluster around three ideal types of welfare regimes had a tremendous impact on social policy analysis. At the heart of his study lies the intention to reveal, through comparative research, the properties that unite

or divide modern welfare states. Esping-Andersen criticizes classical approaches to welfare development for relying on universal laws and the normative question concerning the ideal division of state and market. Instead, he promotes the Weberian concept of ideal types to descriptively and heuristically order social policy development (Esping-Andersen 1990).⁶ This approach has triggered an ongoing and lively debate enriched by a variety of theoretical perspectives. In the context of this study, feminist approaches are particularly relevant, in that they stress the role of women as unpaid caretakers and the impact of the family on welfare provision.

The final decade of the 20th century witnessed what Peter DeLeon and Phyllis Resnick-Terry termed a “comparative renaissance” in social science (DeLeon and Resnick-Terry 1998, 13). The economic, political, cultural, and social processes at the time provoked a scientific debate about the future of the nation state and its systems of social protection.⁷ This debate also led to a shift in welfare state literature. While previous studies have tried to explain welfare state growth and variation, the focus of recent studies has shifted toward the changing role of the state in welfare provision with regard to market interaction, as well as non-governmental and supranational actors. In this context, Paul Pierson’s work should be considered paramount. His contributions to the historical institutionalist approach offer theoretical guidance for analyzing the durability of welfare state institutions and questions of path dependency (Pierson 1996; 2004).

Furthermore, a growing body of literature merging under the heading of governance, argues that policy making in modern societies can no longer be explained as a hierarchically organized government process. Instead, governance approaches highlight forms and mechanisms of coordination of governmental and non-governmental actors through structures of regulation (Majone 1997; Mayntz and Scharpf 2005; Schuppert 2008).

In sum, the last two decades have seen a shift in welfare state literature; with classical theoretical approaches emphasizing the question, why do welfare states emerge? More recent concepts, on the other hand, are underpinned by the question, how are welfare states organized? However, in light of ongoing social policy reforms around the world, scientific debate is set to continue for some time to come.

In contrast to welfare state analysis, the development of sophisticated theoretical approaches to systematically compare healthcare systems is still in its infancy. Until recently, most comparative studies were dominated by research questions stemming from economics and thus focused on the

⁶ According to Esping-Andersen, predominant theoretical explanations of the welfare state stemming from the classical schools of political economy: Marxism, Liberalism, and Conservatism, laid their primary focus on state-market relations and as a result, have been motivated by theoretical concerns about questions of power, industrialization, and capitalist contradictions (Esping-Andersen 1990, 11).

⁷ These processes include population aging, shifts in family structures, slowdown of economic growth, unemployment, increasing budget deficits, privatization, increasing national and international economic competition, and rapid technological change (Ghai 1997, vii).

internal workings of healthcare systems in order to find solutions for common policy problems (Freeman 2000, 8). Only a small number of studies have been based on comprehensive theoretical explanations for political and social embedment, as well as the division of political power within healthcare systems.⁸ Accordingly, as a closer look at this literature shows, most comparative studies focusing on healthcare elaborate directly on the theoretical findings of welfare state analysis (Cacace et al. 2008, 5).

I outline key approaches of welfare state analysis and their reception in healthcare system analysis below in order to develop theoretical guidelines for the analysis of the transformation of the Turkish healthcare system. I argue that the historical institutionalist approach in particular, with its emphasis on the path dependency development of welfare state institutions, offers an effective framework for the analysis of the emergence and transformation of Turkey's healthcare system.

To date however, comparative healthcare analysis has predominantly focused on formal care provision by state and market actors and has neglected the role of informal actors. The regime approach, which integrates formal and informal, as well as governmental and non-governmental actors, offers a capacious framework to validate the hypotheses which underpin this study. Concurrently, findings from feminist scholars provide a more comprehensive picture of the actor constellation which constitutes Turkey's healthcare system. Furthermore, governance approaches help us to understand qualitative changes in the role of the state in healthcare regulation.

1.1 Structuralist approaches

Structuralist approaches elaborate on Marxist theories and stress that the development of welfare states is the outcome of changes in capitalist economies. In particular, the industrial revolution made the development of public institutions that provide welfare both necessary and possible. In this logic, urbanization and demographic change, as well as the rise of individualism and market dependency, put the traditional providers of welfare, such as the family, the church, or local communities, under substantial pressure. As a result, these traditional providers increasingly lacked the capacities to provide welfare to their members. As markets provided social security services for individuals based exclusively on their economic performance, nation states had to engage in the realm of social policy in order to stabilize the capitalist system (Flora and Alber 1981). Simultaneously, economic processes of capitalization and industrialization became the prerequisite for modern welfare programs, providing nation states with the necessary financial resources to establish social security institutions, which in turn were made possible through the rise of modern bureaucracies (O'Conner 1973).

⁸ Among these studies are: Immergut 1992; Freeman 2000; Marmor et al. 2005; Moran 1999; 2000; Burau and Blank 2007; Wendt 2005; 2009; Wendt et al. 2009.

Following this logic, the first generation of cross-national welfare state studies compared indicators of modernization, such as the extent of urbanization and economic growth and demographic data, with the level of public spending for social programs. Deriving the state's commitment to welfare predominantly from its social expenditure, scholars such as Phillipps Cutright (1965) and Harold L. Wilensky (1975) come to the conclusion that economic development correlates with generous public welfare. At the heart of this observation lies the claim that irrespective of institutional and cultural differences, as well as the power of societal groups, modern welfare states follow a convergent path of development leading to a similar set of political, economic, and social institutions (Haberecht 2015, 101).

During the era of welfare austerity in Western and Northern Europe in the 1980s and 1990s, structuralist approaches lost momentum and the academic debate refocused on cross-national variations in welfare state development and on the impact of actors and institutions on social policy. By the end of the 20th century, however, the premise of convergence in welfare state development had re-entered the academic debate. In light of the socio-economic transformations, which are commonly subsumed under the heading of globalization, a large body of literature emerged around the socio-economic outcomes of an unbound global market, the shift towards a post-Fordist economic order and the hegemony of the liberal economic paradigm, as well as the effects these changes had on the authority and legitimacy of nation states in the realm of social policy.⁹ Many of these studies incorporate structuralist arguments and come to the conclusion that welfare states are jointly transforming into what Philip G. Cerny calls competition states.

The crisis of the national Industrial Welfare lies in its decreasing capacity to insulate national economies from the global economy [...]. Today, rather than attempt to take certain economic activities out of the market - to 'decommodify' them as the welfare state was organized to do - the Competition state has pursued increased marketization. This 'commodification of the state' itself aimed at making economic activities located within national territory, or which otherwise contribute to national wealth, more competitive in international and transnational terms (Cerny 2000, 30).

These scholars argue that similar to the industrialist logic which triggered welfare state development, globalization has to be understood as a convergent process with a predetermined ending, a race to the bottom of the welfare states (Altvater and Mahnkopf 1997; Cerny 2000).

This social dumping argument was soon challenged by scholars that offered empirical proof for the durability of welfare state institutions, as well as a transformation of state behavior (Pierson 1996, 147-48). However, the debate over convergent development of social programs continues. A

⁹ For an overview see Held et al. 1999.

multitude of studies examines the conditions under which shared social pressures lead to convergent social policymaking (Bislev 1997; Bouget 2003).¹⁰

In healthcare analysis a number of comparative studies follow the logic of industrialism argument to explain the development of healthcare policies in modern welfare states. The establishment of compulsory health insurance in Bismarckian Germany, for example, is viewed as an attempt to integrate the new working class into the new capitalist economy (Porter 1999, 197).

Furthermore, the global impact of technological development on national health systems has been significant. Elaborating on Karl Polanyi's notion of market society (1944), Brian Abel-Smith (1965) and Milton Roemer (1977) argue that economic growth and rapid expansion of medical technology result in a stronger role of the state in healthcare financing and provision. Similarly, Milton Terris observes a common trend in industrialized capitalist countries toward tax-funded national health systems. He argues that common pressures on nation states to control the rising costs of healthcare, guarantee quality standards, and to decommodify healthcare, leads to similar health policy mixes in industrialized countries (Terris 1978). Mark G. Field also argues in favor of a convergent development of health systems. In this context, he highlights two prime-movers: ideological pressures in society that push toward equity in access of health service provision and the development of technology that forces nation states to further invest in healthcare systems (Field 1989).

In congruence to welfare state literature, structuralist explanations were first displaced by approaches focusing on the diversity of healthcare systems but were later re-introduced to the debate following the onset of the healthcare crisis in industrialized countries. A number of recent studies argue that national health systems are becoming more alike and point to common global trends in the transformation of healthcare policy.

Dov Chernichovsky claims that as health systems have to tackle similar challenges, such as cost containment, efficiency, and equity, they follow a common healthcare paradigm. This paradigm crosses ideological lines and conceptual frameworks and results in a common policy mix regarding financing, organization, and management of health systems (Chernichovsky 1995).

Likewise, Michael Moran's concept of the healthcare state is also based on structuralist arguments and will be discussed in further detail later in this chapter. Moran claims that since the late 19th century, societies in industrialized countries have experienced similar socio-economic processes and technological innovations that turned curative medicine into a precious social good and led to the

¹⁰ Silja Häusermann, for example, states that with the emergence of new social risks, industrialized countries show similar trends in pension sector reform. In contrast to traditional structuralism, she argues that structural change, such as demographic change or labor market transformation, does not necessitate policy reform. However, if structural changes collide with existing political institutions and challenge the social paradigms that led to their establishment, conflicts between actors of modernization and conservation become probable (Häusermann 2010, 197).

invention of health insurance as a means to directly finance the cost of care. This therapeutic revolution left governing bodies with two main tasks: first, deciding on the total volume of resources dedicated to financing healthcare and second, determining the principles on which access to healthcare would be granted to individual patients (Moran 1999, 140).

More recently, however, in light of shared social pressures, health policies across the industrialized world have increasingly focused on the containment of healthcare expenditure through the regulation of price mechanisms. Moran argues that this convergent development has to be understood as an attempt to reverse the historical process of de-commodification of healthcare consumption. However, while healthcare markets have gained importance, this development has not led to a marginalization of the state. Instead, elaborating on governance approaches, Moran observes a convergent trajectory in healthcare reform which he sums up as “more market, more state, more regulation and more bureaucracy” (Ibid., 90).

Elaborating on Moran’s analytical framework, a number of scholars such as Claus Wendt, Simone Grimmeisen, and Heinz Rothgang come to a similar conclusion. While they find little empirical proof for a race to the bottom of healthcare systems, they highlight a convergent change in the role of the state in healthcare provision and the way healthcare systems are regulated (Wendt et al. 2005; Rothgang et al. 2005).

This thesis does not offer a comparative analysis of the transformation of healthcare in Turkey. However, the theoretical assumptions that these scholars derive from their observations—that healthcare systems are in a convergent transformation process—allow us to better understand the workings of the Turkish healthcare system. Additionally, they enable the findings of this study to be put into context.

The question of whether the Turkish healthcare system’s path toward modernization differs from the experiences of mature welfare states is an important one. However, it is beyond the realm of this study to provide an answer. Nevertheless, the analytical framework of this thesis elaborates on the theoretical and methodological approaches of comparative welfare and healthcare system analysis. Accordingly, I put the findings of this study into context in the conclusion, where I examine to what degree the Turkish case suggests a transformation that is convergent or divergent from the developments in other European healthcare systems.

1.2 Power resource approaches and the focus on groups in society

During the times of crisis in Western and Northern European welfare states in the 1970s and 1980s, approaches focusing on the differences between mature welfare states gained popularity. The most significant of these were behaviorist approaches, in particular pluralist and power resource

approaches, which stress the impact of societal groups on social policies. According to pluralist approaches interest groups play a significant role in the processes of policy making. Authors such as David B. Truman (1951) and Robert A. Dahl (1961) argue that political power in society is distributed among community elites who use their resources and expertise to maximize political influence. In this sense, governments function mainly as mediators between different interest groups in society. Pluralists moreover state that the emergence of a ruling elite is precluded by the multiplicity of power sources in society (Immergut 1992, 249).

In the context of welfare state research, pluralist approaches have had limited impact on the academic debate. In healthcare system analysis, however, several studies focus on the influence interest groups, in particular medical professions, have on health policy making. In this context, most studies employing a pluralist framework examine the power of doctors and focus on their financial and organizational resources as well as political contacts.¹¹

More sociological theories on professional power try to explain occupational stratification and establishment of medicine as a profession in society with unique autonomy, privileges and authority.¹² While some scholars outline the challenges to the medical profession (Haug 1988) and highlight the influence of other groups in society, such as patient groups (Harrison and Mort 1998), others highlight the adaptability and the transnational character of the medical profession (Kuhlmann and Burau 2008). Elaborating on Marxist approaches, representatives of the second strand of behavioralist approaches, power resources approaches, such as Esping-Andersen (1985; 1990) and Walter Korpi (1983; 1989), argue that two types of power exist in capitalist democracies: the power over means of production and the power of organized labor. They claim that the state's commitment to welfare and the level of redistribution between labor and capital is determined by the balance of these two powers. Comparing the strength of left wing parties (Huber and Stephens 2001) and labor unions (Korpi 1983; Stephens 1979) with the level of social expenditure, they conclude that a strong organized left correlates with a high degree of welfare de-commodification. Accordingly, welfare states are basically perceived as "outcomes of, and arenas for, conflicts between class-related socio-economic interest groups" (Korpi and Palme 2003, 425).

Few scholars in healthcare analysis follow this logic. One exception, however, is Vincente Navarro who claims that class relationships in a specific country determine the institutionalization of its healthcare systems. Accordingly, he argues that the strong working class in the United Kingdom (UK) resulted in the establishment of a National Health System which provides free healthcare to all citizens (Navarro 1989). However, the overall influence of "power resource approaches" on health system analysis can be considered marginal.

¹¹ For classic pluralist analyses of healthcare systems see: Eckstein 1960; Safran 1967.

¹² Examples are: Freidson 1970; Starr 1982.

In the following chapter I show that since the establishment of modern healthcare institutions in Turkey, the state has exerted strict hierarchical control over social groups and non-state actors in healthcare. Accordingly, behavioralist approaches hold limited value in explaining the Turkish case. Nevertheless, the absence of powerful groups in Turkish social history may explain the overall reluctance of the state to take responsibility of the healthcare of its citizens which has, at least until recently, contributed to the predominant role of the family in welfare provision.

1.3 Institutional approaches

Throughout the 1980s and 1990s, a number of studies in social science and welfare state analysis gained significant popularity that reopened the black box of politics and shifted the academic focus back to the state.¹³

Different nations have developed different institutions, formal and informal, for making political decisions. The formal institutions of government as defined by constitutions are critical to these decisions. But equally important to public policy are the informal practices that have developed around these institutions as interest groups, political parties, individual politicians, and bureaucrats have struggled to bend these institutions to their wills. These “rules of the game” define the political logic for each nation (Immergut 1992, 3-4).

New Institutionalism describes a cluster of theoretical approaches which commonly claim that state institutions are not simply objects of functional convergence or arenas for the conflicts of societal groups, but actively shape policy outcomes. Based on Jean-Jacques Rousseau's (1993) argument that behavior and preferences of individuals are not coincidence but products of the norms and institutions of society, new institutionalist approaches argue that social policy outcomes largely depend on institutional arrangements within the state apparatus (Immergut 1998).

New institutionalist approaches can be subdivided in three categories: the rational choice perspective, sociological institutionalism or organization theory, and historical institutionalism (Hall and Taylor 1996). In welfare state analysis, this third category had a distinct impact on our understanding of the role of institutions in social policy change.

Focusing on the themes of power and interests, historical institutionalism emphasizes how pre-existing institutions distribute power unevenly among societal groups, shape political conflicts and their outcomes, and asserts that various institutional factors filter the transfer of political preferences of actors into politics. In this context, historical institutionalists claim that social life unfolds over time and all social processes have a distinct temporal dimension (Pierson 2004, 5). According to Paul Pierson,

¹³ Classic institutionalist studies are: Skocpol 1979; 1987; Czada 1989; Hecló 1974.

cautious reading of history is the precondition for establishing valid theoretical explanations for social phenomena.¹⁴

Contemporary social scientists typically take a “snapshot” view of political life, but there is a strong case to be made for shifting from snapshots to moving pictures. This means *systematically* situating particular moments (including the present) in a temporal sequence of events and processes stretching over extended periods. Placing politics in time can greatly enrich our understanding of complex social dynamics (Ibid., 1-2).

Essential for this reading of institutional development is the concept of path dependency, which claims that once a path is chosen in politics it may lock in, meaning that all relevant actors adjust their strategies to fit the prevailing pattern. This adaptation to institutional, organizational, and policy settings implies that the costs of alternative settings that were previously available, increase drastically and become far higher than the costs of continuity (Steinmo 2008, 167-68).

[O]nce a country or region has started down a track, the costs of reversal are very high. There will be other choice points, but the entrenchments of certain institutional arrangements obstruct an easy reversal of the initial choice. Perhaps the better metaphor is a tree, rather than a path. From the same trunk, there are many different branches and smaller branches. Although it is possible to turn around or to clamber from one to the other – and essential if the chosen branch dies – the branch on which a climber begins is the one she tends to follow (Levi 1997, in Pierson 2004, 20).

In his critical acclaim of the alleged race to the bottom of modern welfare states, Paul Pierson observes that compared to other political institutions, welfare institutions show a remarkable durability and resistance against reform. He explains this phenomenon by outlining a qualitative difference between politics of welfare expansion and politics of retrenchment. While governments can take credit for popular reforms in times of welfare expansion, politics of welfare retrenchment must be implemented against the scrutiny of voters and interest groups (Pierson 1996, 144-45).

Nevertheless, as Douglass North summarizes, this does not mean that history is predetermined and political change does not occur.

At every step along the way there were choices—political and economic—that provided real alternatives. Path dependency is a way to narrow conceptually the choice set and link decision making through time. It is not a story of inevitability in which the past neatly predicts the future (North 1990, 98-99).

Pierson outlines three conditions under which welfare retrenchment is possible: First, a significant electoral slack allows the government to absorb the consequences of unpopular decisions. Second, budgetary crisis gives the government the chance to present reforms as necessary steps to prevent the

¹⁴ Instead of simply stating that history matters, he calls for theoretical concepts that explain the ways in which temporal contexts matter. Accordingly, historical analysis is not perceived as a method to prove or disprove theoretical hypotheses by revealing empirical evidence. Instead, history becomes a theory itself. He identifies three mechanisms that function as analytical tools in order to investigate temporal processes: path dependency, the role of timing and sequence, and the attention to long-term processes (Pierson 2004, 6).

collapse of social security systems. Third, decision makers in democratically elected institutions find strategies to hide their own responsibility of avoiding the electorate's blame (Pierson 1996, 179).

Essential for the explanation of institutional change is the concept of "critical junctures". While institutional transformation in welfare states is characterized by long periods of path-dependent reproduction, critical junctures are brief periods in which institutional change is possible (Collier and Collier 1991). As Pierson highlights, the policy choices made during these periods are essential for the further trajectory of the transformation of welfare institutions. Hence, they often lay at the very beginning of path-dependent processes (Pierson 2004, 135).

In the field of healthcare, the starting point for many institutionalist studies is the observation that although mature welfare states have managed to almost fully integrate their citizens into public schemes, the institutional apparatuses which finance and provide healthcare vary significantly (Freeman and Rothgang 2010, 370).

Ellen Immergut investigates why, despite similar levels of interest group organization, i.e. of the medical professions, the historical trajectories of health reform in Switzerland, Sweden, and France are highly divergent. According to Immergut, it is the institutional framework for political decision-making that explains why some factors are significant for some polities or historical eras and prove to be irrelevant for others. As such, the ability of interest groups to veto political decisions is not determined by the distribution of power resources within a political system but by institutional configurations. She argues that the probability of political decision-makers to implement reforms largely depends on the existence of institutional veto points within a political system (Immergut 1992).¹⁵

Jacob S. Hacker finds that despite similar cultural, socio-economic, and political characteristics, the UK, Canada, and the United States of America (USA) have developed highly diverse medical systems. He explains this observation through the path dependency of social policy reform and concludes that opportunities for radical change in health policy only come about with the occurrence of critical junctures:

The great difficulty of altering established arrangements in medical care means that opportunities for fundamental change in health policy arrive rarely and momentarily, frequently because of major partisan shifts or significant external shocks. The prospects for policy change during these critical junctures hinge on two factors: the incentives and constraints created by political institutions, and the inherited legacies of past policies, which structure the medical sector, set the intellectual agenda for reform, shape the resources and interests of key societal groups, and influence public perceptions of the cost and benefit of policy change. Changes in public policy made (or not made) during these critical junctures in turn influence future political struggles by

¹⁵ In Switzerland, national referenda were a powerful instrument for doctors' associations to block unpopular reforms, such as the national health insurance or doctor fees. In Sweden, the lack of veto points and the reliance of the executive on stable parliamentary majorities and party discipline enabled the transformation to a national health system. In contrast, in the parliamentary system of France, the lack of clear electoral majorities and absent party discipline made the parliamentary arena a critical decision point for health reform. Accordingly, interest groups could veto political decisions by exerting influence on individual members of parliament.

locking into place particular constellations of interest and institutions and setting in motion self-reinforcing, path-dependent processes that delimit the scope of future policy change (Hacker 1998, 127).

Accordingly, he stresses that the emergence of national health systems cannot be simply explained as a particular event in time caused by a particular constellation of social and political factors, but has to be seen as an ongoing historical process in which sequence is a determining factor (Ibid., 59).

Comparing health reform in Britain, Germany, and the USA, Susan Giaimo and Philip Manow find that the introduction of market mechanisms into healthcare does not automatically entail a retreat of the state, as witnessed with the strong state intervention in the health sectors in Germany and Britain. Furthermore, it does not result in the erosion of public solidarity and the core constituencies of healthcare systems as market elements might be used by political decision-makers to achieve both efficiency and equality. They find that despite common policy goals, such as cost-containment and increased competition, governments choose different political strategies, while their outcomes of reform vary with regard to the effects of solidarity of provision and financing. In line with other institutionalist scholars, Giaimo and Manow argue that the distinct national setting of actors and institutions determines the shape and outcome of reform. In contrast to previous studies, they argue that it is not the analysis of formal public institutions, as proposed by Immergut, but the arrangement of sectoral institutions that allows for the investigation of the trajectory of reform and in particular feedbacks in health policy as defined by Pierson (Giaimo and Manow 1999).

In sum, historical institutionalist approaches offer a comprehensive framework for the analysis of institutional change in the healthcare sector under the AKP government. In particular, the concepts of path dependency and critical juncture allow a better understanding of recent reforms as they put them into context with the long-term transformation of healthcare institutions. In addition, historical institutionalist approaches conceptualize linkages between healthcare reforms and changes in the larger political and socio-economic context.

1.4 Governance approaches and the transformation of state action

Until the 1970s, state intervention in the economy and society was understood as a process of political steering in which the state interfered by means of a hierarchical process. However, economic and social change in the aftermath of the oil price shocks triggered an academic debate over whether complex societies can be successfully governed top-down. New forms of governance were discussed which put the emphasis on cooperation between the state and actors in the market and society, as well as mechanisms of self-regulation. Accordingly, in political theory, the term governance highlights

non-hierarchical, cooperative modes of interaction and the inclusion of public and private actors in the process of policy making.¹⁶

Studies elaborating on governance approaches focus on the transformation of state action and the coordination of public and private actors and institutions through structures of regulation (Schuppert 2008, 23).¹⁷ Many of these studies put their empirical focus on policy instruments which can be defined as “[a] device that is both technical and social, that organizes specific social relations between the state and those it is addressed to, according to the representations and meanings it carries” (Lascoumes and Le Gales 2007, 5, in Le Gales 2011, 144). The analysis of policy instruments aims to contribute to the conceptualization of different forms of governance. In this context, a distinction is being made between “old policy instruments” which correspond to command and control modes of governance such as public services, taxes and laws, and “new policy instruments” such as agreement- or incentive-based instruments which may comprise partnerships and contracts between governmental and non-governmental actors, and other non-hierarchical forms of regulation such as standards, as well as information- and communication-based instruments (Ibid. 2011, 152; Willert 2011, 64-67).

The empirical focus on policy instruments has been crucial for the conceptualization of policy change. Of particular note is the analytical framework developed by Peter Hall which may be considered a milestone in policy analysis. Hall identifies three different components of policy: political goals which underpin the policy, instruments to implement a policy, and different settings of policy instruments. He offers three categories to distinguish between different levels of policy change: A first order change is defined as shifts in the settings of the existing policy instruments. A second order change demands

¹⁶ The concept of governance in social science is not only restricted to the description of cooperative forms of policy-making between states and the market and society. As such, in international relations, the concept is used to describe processes of policymaking beyond the realm of the nation state, such as international organizations or attempts of public and private actors to solve transnational challenges, such as global warming. The academic debate on different forms of governance also had a significant impact on theoretical approaches of European Integration and on analyzing processes of decision-making within “multi-level governance” in the EU (Zürn 1999). Outside social science, the term governance is further used to describe different forms of interaction in the realm of capitalist production or the organization and normative orientation of private companies. Renate Mayntz outlines that in the public debate governance is often used with a normative underpinning, i.e. good governance. As such, the term is positively associated with policymaking characteristics such as self-determination, participation, and effectiveness (Mayntz 2008).

¹⁷ One of the most sophisticated attempts to offer an analytical framework to analyze patterns of regulation and strategic interaction between actors within specific policies is the actor-centered institutionalism developed by Renate Mayntz and Fritz Scharpf. Their approach is based on the premise that social phenomena are the outcome of the interaction of rational actors. Nevertheless, these interactions are shaped to a significant degree by institutions which determine the capacity of political decision-makers to implement reforms. In contrast to rational choice approaches, actor-centered institutionalism argues that institutions not only limit the available choices of actors but also define their constellation, regulate their interaction, and structure their incentives. Despite this importance, actors remain relatively autonomous in their action and the outcome of their interaction again has influence on the institutional framework (Mayntz and Scharpf 1995; 2005).

an alteration of policy instruments and settings. A third order change or paradigm change occurs when the hierarchy of goals, which underpin a policy, changes (Hall 1993). Critics argue that Hall's model lacks the capacity to integrate policy outcomes and that a clear-cut differentiation between the different categories is difficult (Haberecht 2015, 48). However, in the context of this study, Hall's analytical framework is a valuable heuristic device for differentiating between levels of healthcare policy change in Turkey (compare Powell 2008, 12).

The academic discussion on new forms of governance also shifted the debate on changes in the general role of states in capitalist societies. In this context, Giandomenico Majone argues that European governments have reacted to structural pressures, such as European and world economy integration, by adapting their mode of intervention in markets. He observes a transformation from what he calls the "positive state" to the "regulatory state". Prior to the 1970s, governments' priorities lay in the redistribution of goods and the correction of inequities in society created by market failures, through macroeconomic management. Since then, the focus of government action has shifted toward the regulation of market actors via rule-making. This process of state transformation manifests in strategies such as privatization, liberalization, economic, and monetary integration, as well as welfare reform (Majone 1997). Similarly, elaborating on corporatist approaches, Gunnar Folke Schuppert argues that modern nation states increasingly act as "cooperative states" and include non-government actors in decision-making and administrative processes (Schuppert 1989; 2008). Both, Majone and Schuppert see the transformation of modern nation states as proof of their durability, and ability to adapt to changes through institutional reform.

There have been numerous studies over the past decade examining how changes in statehood and governance affect welfare arrangements and lead to shifts in the constellation between governmental and non-governmental actors. Much of these have focused on the impact of privatization, the prioritization of markets, and the creation of welfare markets through public policies, particularly in the fields of pension and healthcare reform.¹⁸

Likewise, in healthcare system analysis, the focus has more recently shifted toward the changing role of the state and healthcare regulation (Tuohy 2003; Rico et al. 2003). One of the most sophisticated analytical frameworks to comparatively analyze the institutional features of healthcare systems is Michael Moran's concept of the healthcare state, defined as those institutionalized forms of social protection that secure its citizens' health on the basis of social rights. Shifting the focus from the organization to the governance of healthcare, he argues that healthcare systems in modern societies have become the scene for significant political struggles over economic resources. The scale and variety of actors and interests involved in these conflicts determine how unique the processes of

¹⁸ For an overview see: Willert 2011, 24-41; Haberecht 2015, 18-34.

governance within the healthcare state are. Accordingly, he claims that the healthcare state cannot simply be perceived as a sub-system of the welfare state as healthcare institutions and other state political institutions pervade each other. “Like any state the healthcare state is about governing; and in the act of governing states shape healthcare institutions, and are in turn shaped by those institutions” (Moran 1999, 4-5).

A number of scholars elaborate on Moran’s concept of the healthcare state by examining the actor constellation of different healthcare systems.¹⁹ Of particular interest in the context of this thesis is the analytical framework developed by Wendt et al. (2009), which examines how the role of the state differs across different healthcare systems and changes over time. Wendt et al. argue that actors constituting healthcare systems can be categorized as the state, the market, and non-governmental actors. These actors exhibit diverse roles and levels of engagement among different healthcare systems and within three key dimensions of healthcare: (i) healthcare financing, based on taxation, insurance premiums or private payments; (ii) healthcare provision, which can take place in facilities owned by the state, non-government or private actors; and (iii) regulation, which comprises state regulation but also self-regulation by non-government actors as well as market mechanisms. They highlight that the state takes a predominant role in healthcare regulation as it sets the boundaries for the level of engagement of non-state actors and, hence, determines different modes of regulation (Ibid., 80).

In sum, the academic debate on new forms of governance and the transformative role of the state in capitalist societies has played a dominant role in social science over the last decade. Likewise, the studies mentioned above, which adapt governance approaches to healthcare system analysis, are of significant importance to the analytical framework of this study. In particular, Hall’s conceptualization of policy change, and Wendt et al.’s framework for the analysis of the transformative role of the state in healthcare systems, are key to examining how changes in healthcare policies under the AKP government have affected the actor constellation of the Turkish healthcare system.

1.5 Regime approaches

Few studies have influenced social policy analysis as much as Esping-Andersen’s pioneering work “The Three Worlds of Welfare Capitalism”. Elaborating on the works of Richard Titmuss (1958) and Thomas H. Marshall (1950), he observes that with regard to the configuration of social programs, OECD countries fall into different clusters. Accordingly, he investigates the properties that unite or divide modern welfare states by focusing on its defining principles. First, the level of de-commodification

¹⁹ See for example: Rothgang et al. 2005; Wendt 2005; 2009; Freeman and Rothgang 2010.

determines to what degree social rights separate an individual's livelihood from its market position. Second, the system of stratification describes how far an individual's class position is either altered or reproduced by social policies. Third, although not based on empirical comparison, he introduces the interaction of the state, the market, and the family in welfare provision into his typology (Esping-Andersen 1990).

Based on this analytical framework, Esping-Andersen observes that three different groups of welfare states have evolved in the OECD that correlate to historical trajectories in class mobilization and political philosophy in the countries he examines. Accordingly, he identifies three different welfare regimes: The Liberal, the Corporatist, and the Social Democratic Welfare Regimes.²⁰ The findings of Esping-Andersen were received with great enthusiasm by the academic community and triggered a series of studies which employ typologies for comparative analysis of welfare states across the globe.²¹

What distinguished his work from previous studies is the claim that the holistic employment of welfare regimes allows different trajectories in welfare state development to be brought into focus. Here, it is the relative stability of ideal types that enables the identification of social and cultural changes. While real type welfare states exhibit hybrid forms, some match the characteristics of ideal typical regimes better than others. Accordingly, "[i]t is the simultaneous knowledge of both the ideal type and the real type that enables holistic ideal types to be used as conceptual instruments for comparison with and measurement of reality" (Watkins 1969 cited in Arts and Gelissen 2002, 139).

Accordingly, typologies have been used to compare healthcare systems. However, most classifications of healthcare systems focus on the internal workings of healthcare provision and are based on different modes of financing and on a dichotomy between public and private ownership of healthcare facilities (Bureau and Blank 2006, 65).

Early health system typologies date back to the 1960s and 1970s. Milton I. Roemer argues that on a global level four different types of health service programs can be identified (1960).²² Mark G. Field

²⁰ The Liberal Welfare Regime, predominantly found in Anglo-Saxon countries, is characterized by strict entitlement rules for means-tested social programs offering typically modest benefits. The level of de-commodification is low while market actors take a significant role in welfare provision. In the Corporatist Welfare Regime, as represented by the welfare state of continental Europe, social programs are erected around the paradigm to preserve class and status differentials. The state takes key responsibility in welfare provision while the market only plays a limited role. Furthermore, the Church is an important actor in welfare provision which leads to a preservation of traditional gender roles. In the Social Democratic Welfare Regime, universal social programs based on citizenship and generous benefits and services lead to a high level of de-commodification and devolution of class differentials.

²¹ For an overview see Arts and Gelissen 2002.

²² In Free Enterprise Types, such as the USA, Canada and Australia, healthcare financing is privately based, and curative care provision, medical education as well as the administration of health insurance mostly lies in the hands of voluntary groups. The level of state penetration in the medical sector is low and the MoH's focus lays on preventive care. In Social Insurance Systems, as found in Central Europe, citizens' access to healthcare is administered by autonomous insurance funds. Primary care is predominantly provided in private medical

employs ideal types of health systems to highlight how mutual structural pressures in the realm of healthcare lead to convergent trajectories among industrial societies, such as the specialization of healthcare provision (1973; 1980).²³ Similarly, Milton Terris argues that the transition from insurance to tax-based funding in Sweden and Britain are exemplary for a global transformation toward free access to healthcare in public facilities (1978).

George J. Schieber's distinction between the National Health Service model, the Social Insurance Model and the Private Insurance Model (OECD 1987) is considered a groundbreaking study in the field. His classification, which is based on a dichotomy between patient sovereignty and social equity, had a significant impact on subsequent healthcare typologies. While its explanatory power was limited to the internal workings of the healthcare apparatus, the study has been used as a starting point for numerous analyses focusing on the political and social embedding of healthcare systems (Brau and Blank 2006, 65).²⁴

In recent years, a number of studies have tried to highlight the close interaction between institutions of healthcare systems and those of the welfare state. Some of these studies argue that the regime approach is also suitable for systematically comparing distinct features of healthcare systems (Bambra 2005a; 2005b; Wendt 2009).

Clare Bambra transfers Esping-Andersen's concept of de-commodification to the realm of healthcare analysis. She defines healthcare de-commodification as "the extent to which an individual's access to healthcare is dependent upon their market position and the extent to which a country's provision of health is independent from the market" (Bambra 2005a, 33).

The starting point for her analysis incorporates two essential critiques of Esping-Andersen's typology. First, Jens Alber's (1995) argument that the concept of de-commodification is unsuitable for measuring the impact of service-based social policies, including healthcare, and second Gregory J. Kasza's (2002) claim that the diversity of a welfare state's social programs makes it impossible to identify a universal logic behind them.

She finds that most countries show consistency when their levels of welfare and healthcare decommodification are compared. She claims that cohesion in welfare and healthcare programs in

practices and secondary care in public hospitals. The MoH determines health standards and supervises health facilities. The third kind of health system is the Public Assistance Type which is predominantly found in underdeveloped parts of the world. In these countries the majority of the population relies on public healthcare providers which are financed through taxation. The MoH is the key actor in curative and preventive care. However, services are insufficient and health standards are low. A fourth type highlighted by Roemer is the Universal Service Type, as found in the Soviet Union, the UK and New Zealand, where state-owned facilities controlled by the MoH offer free primary and secondary care to the entire population.

²³ Elaborating on the structuralist approach, Field outlines five different ideal types of healthcare systems and observes that they are in a convergent process towards a socialized model, where healthcare is provided as a public service by the state.

²⁴ See for example: Freeman 2000; Ham 1997.

most social democratic, and some liberal welfare states, make it possible to identify a predominant political philosophy behind social programs in these countries (Bambra 2005a; 2005b).²⁵

Moran also uses typologies to analyze different healthcare states. He identifies three arenas essential for the governance of healthcare: First, the government of consumption, which is shaped by the struggle for resources allocated to healthcare, as well as the conditions that regulate citizens' access to healthcare; second, the government of healthcare provision, which sets the framework for medical professions and the delivery of healthcare; and third, the government of technology, which is determined by the relationship of institutions engaged with medical innovation and technology (Moran 1999; 2000).

Moran argues that the extent to which healthcare has been decommodified in a country over time has a significant impact on its government of consumption. However, unlike welfare states, it is not the level of de-commodification but the interaction between institutions of the nation state and healthcare institutions that is distinctive for healthcare states. Focusing on this relationship in the three arenas of the healthcare state, Moran observes that healthcare systems in mature welfare states cluster in different families (Moran 1999; 2000).²⁶

²⁵ Carsten Jensen argues that welfare transfers and service provision are the two distinguishing dimensions of welfare regimes. He classifies OECD countries based on their level of social expenditure for welfare transfers, social services and healthcare services. While his findings on welfare transfers and social service provision validate Esping-Andersen's claims about the ideological underpinnings of welfare regimes, as well as the state, market, family relation in welfare provision, in healthcare a different picture is drawn. He observes that OECD countries show only marginal differences in their spending on healthcare services and argues that this makes it impossible to distinguish between different clusters (Jensen 2008).

²⁶ Moran distinguishes between four families of healthcare states. In the Entrenched Command and Control Healthcare State, as found in the UK and Scandinavia, the state is the dominant actor in governing healthcare consumption in all three arenas top-down. It delegates resources from the tax system to the health system and access to the latter is based on citizenship. Most healthcare facilities are in public ownership and professionals are public employees. Accordingly, while technological facilities are in private hands, the predominance of the state in the fields of consumption and provision has a retarding effect on medical innovation. The Supply Healthcare State, as found in the USA and to a certain degree in Switzerland, has been shaped by powerful suppliers that overruled the interests of consumers. The result of the development of highly autonomous and well-organized medical professions and research institutions, has been a strict control of the political decision-making system by supplier interests, a low level of universalism and a large percentage of citizens not being covered by the health system, and an over-complex administrative system. In Corporatist Healthcare States, for which the German case is paradigmatic, the government of consumption is marked by a state that plays an insignificant role in healthcare financing and primarily functions as a regulator of powerful public law bodies. These collect social insurance contributions and purchase healthcare services and goods. Medical professions are well organized and have significant influence on the government of provision especially in the ambulatory sector. The state has limited influence over the institutions of healthcare production. Finally, the Insecure Command and Control Healthcare States, represented by the southern European countries of Spain, Greece, Italy, and Portugal, redesigned their health systems from the 1970s onwards, according to the model of the Entrenched Command and Control Healthcare States. Nevertheless, as the health systems of these countries are embedded in a political culture devoid of the administrative rationality found in northern Europe, and furthermore were established during an era of welfare austerity, the southern European states failed to exert greater influence over the institutions of healthcare consumption and provision. Accordingly, despite constitutional commitment to healthcare as a social right based on citizenship, private insurance and out-of-pocket payments play a significant

Elaborating on Moran's concept of the healthcare state, a number of scholars have more recently employed typologies to compare different arrangements between government and non-government actors in the fields of healthcare financing, provision, and regulation.²⁷

Wendt et al.'s study is particularly relevant for my analysis of the transformation of the Turkish healthcare system. Elaborating on the literature that investigates the changing role of the state in welfare provision, they focus on shifts in healthcare governance. Their aim is to establish an analytical framework, which not only allows the comparison of nation states, but tracks the internal transformation of individual healthcare systems over time (Wendt et al. 2009, 82).²⁸

As discussed, Wendt et al. identify three key dimensions of healthcare systems, namely financing, health service provision, and regulation. Furthermore, they highlight three groups of actors which are relevant in these dimensions: the state, non-governmental actors, and the market. Finally, in order to construct their typology, Wendt et al. create ideal types based on the potential role of these three actors in healthcare across the three dimensions.

In the financing dimension, taxation, social insurance contributions and private financing are distinct forms of financing which can be directly attributed to the three relevant actors. Taxation, they claim, is a form of state financing, while out-of-pocket-payments and private health insurance constitute a market-based form of funding. Social insurance counts as a form of societal-based financing as the state has no access to the revenues of social insurance funds, entitlement is not based on citizenship but given on the basis of a specific contribution which may already be mandatory, and, finally, as it tends to have some element of ex ante distribution. Although financing combinations are common, most real types clearly lean toward a single form of funding which makes it possible to classify them according to dominant funding types.

In the dimension of healthcare provision, Wendt et al. distinguish between state services, which are provided by public and not-for-profit actors; services provided by the market, which are private and for-profit; and societal-based services, which are provided in non-government and not-for-profit

role in healthcare financing and a large percentage of healthcare facilities are in private hands (Moran 1999; 2000).

²⁷ See for example: Wendt 2005; 2009; Wendt et al. 2009; Rothgang et al. 2005; Freeman and Rothgang 2010.

²⁸ In examining patterns of regulation in healthcare, Wendt et al. identify three different ideal types of healthcare systems: State Healthcare Systems, such as in the UK, Scandinavia and Denmark, or in the countries in Central and Eastern Europe before the fall of communism, are characterized by a dominance of state actors in financing, provision and regulation. In Societal healthcare systems, such as in pre-1970 Denmark and the Southern European countries, the three areas are bestriden by non-government actors. Finally, in private healthcare systems, formerly found in the USA, the market dominates the health system entirely. Furthermore, four different types of mixed-types exist: State-based mixed-types, which can be found in Central and Eastern Europe and Southern European countries, Societal-based mixed-types, such as in Germany, and private-based mixed-types, such as in today's USA, and pure mixed-types. Similarly, Claus Wendt focuses on patterns of regulation in cross-national comparison using both quantitative as well as qualitative data (Wendt et al. 2009).

facilities. Accordingly, in this dimension the classification of healthcare systems is based on ownership criteria and the profit-orientation of providers.

As regard the regulation of healthcare, Wendt et al. highlight the existence of forms of non-state led regulation, such as market-driven or corporate-governed. However, as the state sets the boundaries of the engagement of private and societal actors in healthcare regulation, its role is paramount. Wendt et al. investigate the relationship of state, societal and market actors in healthcare regulation on three different levels: (i) the regulation of the relationship between beneficiaries and financing agencies, which touches on issues related to the coverage and financing of healthcare systems; (ii) the regulation of the relationship between financing agencies and service providers, which affects the remuneration of providers and their access to the healthcare market; and (iii) the relationship between service providers and beneficiaries, which has an impact on patients' access to care, as well as the type and range of available services. They argue that in order to systematically compare healthcare system regulation the main actor within these three levels needs to be identified. However, they do not offer a specific set of indicators to master this challenge (Ibid.).

In order to track different forms of internal system transformation over time, Wendt et al. elaborate on Peter Hall's (1993) model of institutional change. They distinguish between three extents of change: First, in the case of a "system change" the predominant actor of a system changes, as seen in southern Europe in the 1970s and 1980s when the societal insurance systems were transformed into state-led systems after the introduction of NHS systems. Second, after an "internal system change" the predominant actor remains overall unchallenged but loses its position in one of the three dimensions. This was the case in the USA, which shifted from a private-based ideal type to a private-based mixed type after the state became the predominant actor in healthcare financing due to heavy tax subsidies. Finally, an "internal change of levels" occurs when policy changes in one dimension lead to sub-dimension changes but do not affect the overall predominance of the actor at hand. This was the case after the introduction of internal healthcare markets in the UK. While market actors gained importance in the regulation of the relationship between financing agencies and service providers, the state remained the predominant actor in healthcare regulation (Wendt et al. 2009).

In this thesis, I aim to analyze changes in healthcare policy and shifts in the actor constellation which constitutes the Turkish healthcare system. Here, the academic debate on different typologies of healthcare systems and, in particular, the analytical framework developed by Wendt et al., offers substantial insights. Accordingly, it constitutes a key element of the analytical framework of this study.

In the existing literature, the Turkish welfare state has been commonly described as immature and the general reluctance of the state to engage in social policies has been outlined (Buğra and Keyder 2005; 2006; Buğra 2007; Grütjen 2008). More recent studies argue that social policy reforms under the AKP government have been based on a neo-liberal paradigm (Yılmaz 2013; Göçmen Yeginoğlu 2010). As

briefly discussed in the introduction, the AKP's healthcare reforms suggest a comprehensive restructuring of the healthcare sector in Turkey and this study aims to examine to what degree these reforms imply a new role of the state in the realm of healthcare. In reference to the academic debate triggered by Kasza, this study's findings may serve as a starting point for further research which can unveil the general ideological underpinnings of social programs in Turkey and their recent reform.

1.6 Feminist approaches

At the heart of feminist scholarship lies the normative concept of gender, developed "to contest the naturalization of sexual difference in multiple arenas of struggle. Feminist theory and practice around gender seek to explain and change historical systems of sexual difference, whereby 'men' and 'women' are socially constituted and positioned in relations of hierarchy and antagonism" (Haraway 1989, 79). Accordingly, scholars who analyze welfare states based on feminist approaches investigate how gender is both constituting and being constituted by social policies.

In retrospect, Esping-Andersen's typology of welfare regimes, or more accurately its shortcomings, has given major impetus to the development of theoretical approaches that highlight the neglect of gender, as well as inter-generational issues in mainstream scholarship, and that analyze the role of women and the family in the formation and development of welfare states (Orloff 2009, 318-19).

Feminist studies criticize Esping-Andersen's typology for focusing exclusively on the social rights of employees in the formal labor market and disregarding women's unpaid work within the household, which, as they argue, is a structuring element of every welfare regime.

[T]he worker Esping-Andersen has in mind is male and his mobilization may actually depend as much on unpaid female household labor as on social welfare policies. Decommodification for women is likely to result in their carrying out unpaid caregiving work; in other words, to use the term of the New Right in Britain and the United States, "welfare dependency" on the part of adult women is actually likely to result in the greater independence of another person, young or old (Lewis 1997, 162).

This claim was broadly acknowledged by the scientific community and later integrated into mainstream welfare state scholarship, mainly by analyzing to what degree social programs liberate women from their traditional role within the household and allow them to participate in the formal labor market.²⁹

Feminist scholars stress that the prerequisite for the commodification of men's labor force is the unpaid work of women in the household. In reverse, women are decommodified by their role within the family. At the same time, social policies are designed according to a male breadwinner model, which is based on the ideal of a male earner in full-time employment, and perceives the role of

²⁹ See for example: Esping-Andersen 1999; 2002; Huber and Stephens 2001.

women mainly as caregivers within the families. By interlinking women's access to social insurance benefits with the labor market status of the primary male earner in the family, traditional role division within the households are reproduced and the economic dependency of women invigorated. Therefore, while social programs alter the market position of the male breadwinner, it is women's position within the household which determines if they are decommodified or commodified by social programs (Langan and Ostner 1991; Lewis 1997; 2006).

Scholars, such as Jane Lewis and Ilona Ostner, call for new analytical models to investigate the gendered underpinnings of social policies and highlight that the male breadwinner concept cuts across existing typologies of welfare regimes. Focusing on female labor market participation and the way it is encouraged by social programs, they come to the result that classifications based on gender differ from those that focus on class-related characteristics (Lewis and Ostner 1994).

In contrast, Ann S. Orloff (1993) stresses the theoretical potential of the incorporation of the gender dimension into mainstream welfare state research. Similarly, Diane Sainsbury underlines the complexity of the dynamics between gender and welfare state policies. By analyzing international differences within the entitlement to social programs and benefits, she observes that social policies are underpinned by numerous and possibly competing principles. Accordingly, she argues that mono-causal explanations, focusing exclusively on de-commodification or the institutionalization of the male-breadwinner, fail to display the complexity of welfare states. Instead, she stresses the necessity to investigate the underlying principles of social programs that intersect both gender as well as welfare state regimes (Sainsbury 1999).

One attempt to analytically frame the impact of social policies on dependency of women within households is the concept of defamilialization first developed by Ruth Lister. Elaborating on Orloff's (1993) concept of household autonomy, she defines defamilialization as "the degree to which individual adults can uphold a socially acceptable standard of living, independently of family relationships, either through paid work or through social security provisions" (Lister 1997, 173).

More recent feminist studies take a critical perspective on the social outcomes of the growing commodification of women's labor and its effects, especially with regard to work-family reconciliation, inter-generational care arrangements within the family, and informal care work. These studies highlight the socio-economic impacts of the growing participation of women in the formal labor market and the shift from the male breadwinner model to what Jane Lewis and Susanna Guillari call the "adult worker model family" (Lewis and Guillari 2005). Orloff observes that within the framework of the general change of discourse from welfare to workfare, social programs supporting women as full-time caregivers are replaced by policies that aim at female employment and individual autonomy. She claims that this "farewell to maternalism" is neither accompanied by a better provision of public or commercial care services, nor higher participation rates of men in care provision, resulting in women

having to face the dilemma of reconciling employment and informal care work within the households. Elaborating on Nancy Fraser's model of "universal caregiver" (1994), Orloff stresses the necessity of developing social programs, that on the one hand, induce men to participate equally in care work, and on the other hand, leave individuals the economic independence to choose between formal employment and care work within the households (Orloff 2006, 4).

The linkage between gendered division of labor, family models, and social policy become especially evident in the realm of care, which has been the subject of a growing body of literature. Taking the importance of service provision in the health sector into account, it appears surprising that healthcare, in contrast to care for the elderly, disabled, or children, has so far been neglected by feminist scholarship. One possible explanation for this phenomenon is the high level of formalization and professionalization of care for the sick in mature welfare states.

Care as a social phenomenon, as well as an academic concept, cuts across various divisions of society, such as the public and private, formal and informal, paid and unpaid, and professional and unprofessional (Kröger 2001, 4). Accordingly, the term is used with different meanings and contexts. Early studies in the field perceived care mainly as a structuring element in society that framed the reality of women. They emphasized that care work within the household was not simply unpaid services but intertwined with a specific set of normative values, such as obligation and love that defined the relationship of women to the other members of the household and accordingly, their position in society (Finch and Groves 1983; Lewis and Meredith 1988).

More recent studies elaborate on the theoretical and methodological approaches of comparative welfare state analysis and focus on the complex actor arrangements through which care is provided. Among the first to establish a typology of care regimes were Anneli Anttonen and Jorma Sipilä. They claim that in cross-national comparison systematic patterns emerge with regard to women's wage employment, and the volume and manner in which care services are organized. In particular, they highlight the similarities between two care regime types: Scandinavian countries are characterized by high female employment rates and widely available care services, either organized by decentralized public actors or non-profit voluntary organization. In contrast, in Southern European countries, women's participation in the labor force is low and care services are either provided by the informal sector or commercial providers (Anttonen and Sipilä 1996).

Stressing the linkage of care and questions of citizenship Trudie Kijn and Monique Kremer put the rights and needs of both caregivers and care receivers into focus. Similar to Orloff, they observe essential differences in the degree to which welfare states leave their citizens a choice of whether to integrate care into their lives or not.

Only when both the right to give and the right to receive care are assured can citizens (caregivers as well as care receivers) have a real choice about how they want to integrate care in their lives.

Only then are people able to choose, at specific times within their life course, whether they need time to care, time to be cared for, or whether they need professional care (Knijn and Kremer 1997, 333).

Elaborating on Adalbert Evers and Herbert Wintersberger's concept of "welfare mix" (1990), Mary Daly and Jane Lewis stress that the state, the market, and the family, as well as the voluntary sector, intersect in the provision of care (Daly and Lewis 2000).³⁰

In analogy to the scholarship on the transformation of the welfare state, more recent literature on care focuses on processes of transformation on the organization of social care. In this context, numerous studies discuss the growing need for care, caused by higher participation rates of women in the formal labor market, demographic change, and changes in the family. However, it has to be outlined that in contrast to the alleged decline of the welfare state, state provision in the realm of care for the elderly and children in mature welfare states has increased considerably (Orloff 2009, 326). At the same time, informal care itself has changed and new models of care provision have developed. Mainly resorting to the labor force of female migrant workers, informal care employment has gained significant importance, and not only in European countries (Hillmann 2005; Simonazzi 2009). New forms of semi-formal, family-based care work have also evolved (Pfau-Effinger and Geissler 2005, 8). Closely interlinked to social programs and transfers based on what Knijn and Kremer have called "the right to give care", a growing number of children and the elderly are being taken care of within the households. As a result, the predominant perception of informal care has changed in many European countries. "[A] new type of home-caring parent or more general, home-caring relative has emerged, who treats home care as a transitional stage of the life course, receives financial transfers from the welfare state and is protected by social security systems" (Ibid., 9).

Accordingly, Birgit Pfau-Effinger and Birgit Geissler stress, that although European countries show considerable differences with regard to the degree care has been formalized, the level of public care provision alone gives little insight about a welfare state's effort to support women's labor force participation and gender equality. Instead, they stress the impact of culture on social change and argue that informal care itself has modernized over the last few decades and that the state's promotion of informal family care does not necessarily contradict gender equality.

[T]he structure of the welfare mix in relation to care and the relationship of formal and informal care are embedded, in specific ways, into the institutional settings of the welfare state, the labor market structures, family, the market, and non-profit organizations. Furthermore, they are also entrenched into social structures such as social inequality (through class, gender, ethnicity, and so

³⁰ In congruence to Sainsbury's work, they claim that the focus on specific policy domains or social programs gives little insight into the interaction of the forces that constitute modern welfare states. In an attempt to bring together welfare and care literature, they argue that the ambiguous meaning and dichotomous usage of the term care prevents its employment as an analytical tool for welfare state analysis. As an alternative, they suggest the concept of "social care" defined as "the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out" (Daly and Lewis 2000, 285).

on) and power relations. Moreover, they are influenced by the dominant cultural values and models ('Leitbilder') concerning the family and welfare in society, the main actors refer with their ideas and interests on the one hand to cultural values and models and on the other to the institutional and socio-structural framework. It should be considered that the cultural system and the social system are themselves related [...] (Ibid., 23).

They claim that two different sets of values frame care arrangements: family values including cultural perceptions of family structure and the gendered division of labor; and welfare values, which relate to the institutions responsible for care outside the family, the re-distributive role of the welfare state, as well as the definition and quality of social rights. Resorting to institutionalist approaches of welfare state development, Pfau-Effinger and Geissler argue that while change within care arrangements might occur due to external factors, their transformation will usually be path-dependent. Nevertheless, the outcome of social change is to a large degree shaped by both family and welfare values. Accordingly, although a country follows the familialistic path of care arrangement, the outcome of policy formation might to a significant degree be influenced by its welfare regime and the core principles it is designed after (Ibid.).

A number of studies highlight the predominance of the family in welfare provision in Turkey (Buğra and Keyder 2006; Kalaycıoğlu 2006; Grütjen 2008). Accordingly, integrating theoretical findings of feminist approaches into the analytical framework of this study is essential to paint a comprehensive picture of the Turkish healthcare system. By integrating the family's role into the analysis of the healthcare system, I enter uncharted territory. I show that the family is a key pillar of the Turkish healthcare system and that women play a key role as unpaid healthcare givers. Accordingly, feminist approaches and concepts hold great explanatory power in the Turkish context. At the same time, given the current debate in mature welfare states on the integration of households into formal healthcare provision, a better understanding of the role of the family in the Turkish healthcare system may also enhance our understanding of its relationship to the state, the market, and non-governmental actors in other societies.

1.7 Interim results

In this chapter, I have summarized the key approaches in welfare state analysis and their reception in healthcare system analysis. I have shown that these approaches vary with regard to their capacity to theoretically and methodologically guide the intended analysis of healthcare policy changes and shifts in the actor constellation which constitutes the Turkish healthcare system under the AKP government. Particularly useful for this study is the framework for the analysis of healthcare systems transformation developed by Wendt et al., which combines the regime approach with the key assumptions of governance approaches. Given that the family plays a predominant role in welfare provision in Turkey,

I adapt this analytical framework and integrate the principles of feminist approaches to welfare state research.

Furthermore, I employ the dominant concepts of the historical institutionalist approach in order to put the findings on policy and healthcare system changes under the AKP government in perspective with the long-term transformation of state and healthcare institutions in Turkey. These approaches theoretically inform the hypotheses which I present in Chapter 4.

2. Historical institutional framework

This chapter comprises an historical analysis of the emergence of the political and healthcare institutions that shape the current actor arrangement of the Turkish healthcare system. Guided by the historical institutionalist approach and predominantly based on secondary literature, I trace the origins of modern state and healthcare institutions back to the late Ottoman Empire. I show that the centralist and authoritarian understanding of statehood that evolved in this era shaped the architecture of healthcare institutions, and resulted in the hierarchical state control over non-governmental actors and the market in healthcare financing and provision in the following decades. Furthermore, I argue that the state assumed only a reluctant responsibility for the healthcare of its citizens, and that the combination of immature healthcare provision through state institutions and the strict control of non-state actors, restored and strengthened the role of the family in Turkey's healthcare system.

2.1 The Ottoman legacy – The inception of state dominance over healthcare provision

The emergence of modern healthcare institutions and state involvement in healthcare financing, provision, and regulation in what is now present-day Turkey, can be traced back to the late Ottoman Empire. Prior to this, professional healthcare was either provided by hospitals (*darüşşifa*) that were owned and managed by religious foundations (*vakıf* in modern Turkish); or by private physicians working in an unregulated healthcare market (Günergun and Etker 2009, 82-87).³¹ The Ottoman state did not consider ensuring the health of its citizens as its duty (Demirci and Somel 2008, 380).³²

This changed during the 19th century when the Ottoman Empire came to be referred to as the “sick man of Europe”. With its rulers attempting to cling onto the remains of their power and international position, the Ottoman Empire stepped into an era of fundamental modernization. Over the previous centuries, power struggles between branches of the political elite and local rulers had undermined the sultan's position. In response, during the reigns of Sultan Selim III (1789-1807) and Sultan Mahmud II (1808-1839), political authority was centralized and an attempt was made to establish a state

³¹ Prior to the 19th century, public welfare in the Ottoman Empire was predominantly provided through religious foundations. They constructed and maintained mosques and educational centers and managed social facilities such as soup kitchens and hospitals (Peri 1992, 167; Günergun and Etker 2009, 82). Controlled by the Ottoman religious leaders, these semi-formal philanthropic foundations were financed by generous acts of the Ottoman rulers as well as voluntary contributions of private individuals and associations (Lewis 1961, 93; Buğra 2007, 37).

³² It can be assumed that the capacities of *darüşşifa* were limited. In the 17th century, only a marginal percentage of physicians worked in *darüşşifa* (Kalkan 2004, 9). Until the mid-16th century, *darüşşifa* also provided medical education (Günergun and Etker 2009, 83). However, the majority of Ottoman doctors were educated on a master-apprentice basis and worked independently on a fee-for-service basis (Kalkan 2004, 9; Sarı 2005). The only institution in the central state engaged with issues of healthcare was the Chief Physician (*hekim başı*) who supervised public health institutions and professionals in the Ottoman capital. Hospitals and medical schools outside Istanbul were not regulated by the central authority (Ayduz 2007, 12).

apparatus designed on the Central European model. Ministries and a modern army were established and the old elites were replaced by a class of civil bureaucrats. Between 1839 and 1876, this reform project was pursued by the *Tanzimat* statesmen. Uncontested by a series of weak sultans, this new class of bureaucrats became the major force behind the modernization and secularization of the Empire.³³

In 1878, Sultan Abdülhamid II (1876-1909) put an end to the *Tanzimat* rule and temporarily restored the power of the sultanate. While he extended many of the technological reforms of his predecessors, he also tried to reverse cultural Westernization and re-emphasized Islamic traditions. But the seeds of nationalism had been sown. In 1908, the so-called Young Turks, mostly nationalistic Muslim Turks that belonged to the military, revolted against the sultan. Until 1918, the Empire was technically governed by the Young Turk movement which was grounded in the Ottoman armed forces and institutionalized in the Committee for Union and Progress. However, the Young Turks could not halt the decline of the Ottoman Empire. A series of military losses culminated in the Empire's defeat in World War I. At the same time, ethnic conflicts, including the Armenian Genocide in 1915, killed and displaced millions of people. Western Allies occupied Istanbul in 1918, and in 1920, the division of the Empire was determined by the Treaty of Sevres. When the Greek army, backed by Allied forces, landed in Izmir in 1919, the War of Independence broke out. In 1922, the Ottoman army defeated the Allies under the command of Mustafa Kemal Paşa who would proclaim the Turkish Republic a year later.³⁴

The transformation of the Empire during the 19th century created a critical juncture that had a direct impact on the role of the state in welfare and healthcare provision. Most importantly, the central government established itself as the key regulator of private welfare institutions. In 1826, all religious foundations were centralized under the administration of the Ministry of Imperial Religious Foundations (*Evkaf-ı Hümayun Nezareti*) in order to control their financial resources (Barnes 1986, 44-45). In this context, it is important to note that the overall impact of Ottoman foundations on poverty relief and healthcare can be considered limited. Only a small percentage of foundations actually funded welfare institutions. The vast majority simply served the interests of members of the religious establishment (*ulema*) as a way of avoiding taxation (Özbek 1999, 6-7).

The centralization of philanthropic foundations during the early 19th century was a significant turning point in Ottoman social history. The subsequent reforms of Mahmud II led to a considerable

³³ During the *Tanzimat* period, which can be translated as reorganization, European laws, administrative structures and procedures were copied and implemented by a growing state apparatus. Newly established institutions were staffed with a new bureaucratic elite (Lewis 1961, 96-97). In 1876, the reforms reached their climax with the declaration of the first Ottoman Constitution which effectively turned the Empire into a parliamentary democracy and reduced the sultan's role to that of a constitutional monarch (Zürcher 2004, 72-73).

³⁴ For an overview of the history of the late Ottoman Empire see: Findley 1980; Lewis 1961, 21-39; Keyder 1987, 25-48; İnalçık and Quataert 1997, 761-77; Zürcher 2004, 9-76.

strengthening of the central state's role in the regulation of the social system, including healthcare provision (Ibid., 10; Ağartan 2008, 130; Demirci and Somel 2008, 380-82).³⁵ Accordingly, the centralization of the *vakıf* system marks the beginning of a path-dependent process that is characterized by a hierarchical relationship between the state and non-governmental institutions engaged in welfare provision (Buğra 2007, 37-38; see also Heper 2000). Further research in the field is necessary, however, to examine to what degree the marginal role religious institutions play in welfare provision today is rooted in the secularization of the *vakıf* system and the marginalization of the *ulema*.

Throughout the 19th century and the beginning of the 20th century, the state continued to execute hierarchical control over healthcare institutions and established itself as the sole actor in healthcare policy making (Ağartan 2008, 132). In the mid-19th century, new actors entered the scene. The first medical association, the Society of Ottoman Medicine (*Cemiyet-i Tıbbiye-i Osmaniye*), was established in 1866 and the Ottoman Red Crescent Society (*Osmanlı Hilal-i Ahmer Cemiyeti*) in 1869 (Günel 2008, 207; Özbek 1999; Buğra 2007, 28). Abdülhamid II perceived these non-governmental organizations, whose members were mostly part of the *Tanzimat* bureaucratic elite, as a threat to his authority and put significant effort into curbing their influence.³⁶

The sultan's concern here was not simply the potential organizational opportunities this society might have provided to the constitutional opposition. He was also anxious to keep his monopoly in the arena of charity, relief, assistance and aid (Özbek 1999, 26).

After the revolution of 1908, the Young Turks established a number of institutions to further regulate and control the provision of healthcare. The administration of all hospitals was centralized under the Directorate General for Health and Public Assistance (*Müessesat-ı Hayriye-i Sıhhiye Müdüriyeti*). In 1912, the Public Health Directorate was founded within the Ministry of Internal Affairs (*Dahiliye Nezareti Sıhhiye Müdüriyet-i Umumiye*). After the reorganization of the Ministry of Interior Affairs and Health (*Dahiliye ve Sıhhiye Nezareti*) in 1914, all sanitary measures were coordinated by a single institution. In 1920, the Ministry of Health and Social Assistance (*Sıhhat ve İctimaî Muavenet Vekâleti*), later Ministry of Health (*Sağlık Bakanlığı*), hereafter referred to as MoH, was founded (Günel 2008, 146-47).

³⁵ After 1826, the Ministry of Imperial Religious Foundations supervised all hospitals. Regular reports on financial affairs but also other matters, such as the number of deceased patients, became mandatory. The ministry was also in charge of building new hospitals and set standards for public health facilities which were inspected regularly (Günergun and Etker 2009, 89; Shefer 2005, 342-43).

³⁶ First attempts to create a voluntary aid society for disabled soldiers can be traced back to the 1860s, when in the aftermath of the Geneva Convention of the International Red Cross of 1865, a provisional Ottoman committee (*Mecruhın Askeriye İane Cemiyeti Umumiyesi İstanbul Komitesi*) was founded. This committee was supported by individual members of the bureaucratic elite, as well as the imperial family, but gained strong opposition from the government, which stripped it of its financial assets as it was viewed as an interference in military affairs (Özbek 1999, 23-29).

Another development in the 19th century that had a significant impact on the establishment of healthcare institutions was the foundation of a modern Ottoman army. Similar to the experience of mature European welfare states, the modernization of the Ottoman military contributed enormously to the establishment of new institutions and capacity building in the realm of preventive and curative healthcare (Ağartan 2008, 136). The state established medical schools to educate qualified health professionals for the military, which led to a significant modernization of the medical profession and to the introduction of healthcare standards (Kalkan 2004, 10-12; İlikan 2006, 81-82, Güngörmüş and Etker 2009, 87-88).³⁷

Furthermore, with disastrous loss of military and civilian life across the empire due to disease, first preventive care policies were introduced.³⁸ From 1871 onwards, the central authority sent civilian doctors to the provinces to inform the central administration on epidemic diseases. This development is remarkable, not only because these so-called government physicians (*hükümet tabibi*) were the Empire's first state-employed and salaried civilian doctors, but also because the policy of sending physicians to the periphery persists until today (Günel 2008, 147). This new awareness of the population's health was accompanied by pronatalist policies and the abolition of abortion.³⁹ These developments, similar to the developments in Central Europe, reflect a new discourse of a healthy population as the prerequisite of a prosperous state and a powerful army (Ağartan 2008, 129).

Nevertheless, it needs to be highlighted that in the 19th century, the state's role in healthcare was limited to healthcare regulation and the provision of preventive healthcare. While the state regulated the medical professions and managed preventive care programs it played no active role in curative care. This also manifested in the structure of the health ministry, which was mainly established to set up and manage preventive care facilities and to fight infectious diseases (Günel 2008, 147-52).⁴⁰

³⁷ Due to the lack of qualified officers, one of the most serious defects of the new Ottoman army, secular schools with military purpose were established. Among the first medical schools was the School for Medicine and Surgery (*Tibhane-i Amire ve Cerrahhane-i Amire*) which was founded in 1827 in Istanbul. Their graduates later staffed the first Civilian Medical School (*Mekteb-i Tibbiye-i Mülkiye*) which was established in 1867 (Kalkan 2004, 10-12).

³⁸ In 1838, the Quarantine Assembly (*Meclis-i Tahaffuz*) and the High Quarantine Assembly (*Meclis-i Tahaffuz-ı Sanı*) were established in order to manage quarantine stations in the Empire's major harbors (İnalçık and Quataert 1997, 787).

³⁹ In prior times, abortion within the first four months of pregnancy was neither illegal, nor considered a sin by the predominant *Hanafi* legal tradition in Islam. By interfering in matters of sexual recreation the Ottoman state interfered in family life, which had until then been considered inviolable. Additionally, the central state interfered in private law, which in prior times came under the authority of the *ulema* (Demirci and Somel 2008, 418).

⁴⁰ The civilian Muslim population predominantly received care from private doctors or the traditional *darüşşifa* organized by *vakıf* trusts. One of the few exceptions was the Imperial Hospital for Children (*Hamidiye Etfal Hastahane-i Âlisi*) erected by Abdülhamid II in 1899. Between 1899 and 1907, more than 10,000 children received inpatient, and more than 100,000 children received outpatient care in the hospital (Özbek 1999, 51). At the same time, the ethnical division of social classes in the Empire manifested in the establishment of public healthcare institutions. The Christian and Jewish minorities in the Empire had already begun in the 18th century

In sum, prior to the 19th century, the Ottoman state played no active role in healthcare financing, provision and regulation. Professional healthcare was either provided as a commodity or charity. The collapse of the old power structures and the Empire's centralization and secularization created a critical juncture that marked the starting point of a new institutional legacy. In particular, the establishment of a modern army and preventive care policies resulted in the modernization of medicine and laid the ground for the foundation of modern healthcare institutions. At the same time, the state emerged as the main regulator of healthcare provision. New state institutions were established, which exerted a high level of control over non-governmental healthcare providers as well as the medical professions and related associations.

However, healthcare policies focused on the health of the population in general and the army in particular. The individual citizen's health was not of concern for the Ottoman state. In order to have access to curative care, subjects of Ottoman rule had to resort to the few existing hospitals, self-employed physicians, or, perhaps most importantly, informal care networks.

2.2 The early years of the Republic – Health policy as a means for nation building and modernization (1923-1950)

On 29 October 1923, the first Turkish president, Kemal Atatürk, proclaimed the Republic. As head of the newborn nation and unchallenged leader of the Republican People's Party (*Cumhuriyet Halk Partisi*, CHP) he and his followers had managed to gather all political power in the hands of the central authority, which did not tolerate any kind of political opposition.⁴¹ Critical newspapers were banned, political parties and labor unions were declared illegal, and strikes abolished. Non-governmental organizations were banned, ranging from Freemason lodges to the Turkish Women's Association (*Türk*

to establish their own hospitals. Comparable to the *darüşşifa*, these hospitals were funded by donations from generous community members and managed by *vakıf* trusts. Especially during the second half of the 19th century, these hospitals developed into significant institutions for the provision of healthcare to the Ottoman urban population. The first Greek hospital, the Balıklı Rum Hastanesi, had already been founded in 1753. The first catholic Armenian hospital was built in 1801 in Istanbul's Beyoğlu district. In 1831, the Catholic Armenians built Surp Hagop, a hospital consisting of 90 beds, half of which were reserved for acute cases, and the other half which served as residence for senior citizens with physical disabilities. Armenian hospitals were also built in Izmir (1801) and in Bursa (1844). Furthermore, Western powers funded civilian and military hospitals for the French, German, Austrian-Hungarian, Italian, British and later American (1920) minorities (Yarman 2001; Fuhrmann 2009).

⁴¹ The remains of the old powers were attacked by taking measures against the religious establishment. In March 1924, the Caliphate was abolished. Religious schools and courts practicing *şeriat* (sharia) law were shut down by the central authority (Lewis 1961, 265). The extinction of the Ottoman heritage through political and legal reforms was followed by a top-down cultural revolution. In the years following 1928, the central authority tried to erase, through a series of reforms, all visible remains of its Ottoman past, including cultural and religious heritage. Among other reforms, the Arabic script was replaced by the Latin alphabet, Sunday was declared the official day of rest, the Western clock and calendar were introduced, and Turkish citizens had to adopt a surname (Zürcher 2004, 186-90).

Kadınlar Birliği). Although parliamentary elections were held every four years, they only served a ceremonial function. Atatürk and his followers in the CHP had established an authoritarian one-party state, sacrificing the ideal of democracy for their project of modernization and secularization (Zürcher 2004, 176-81).⁴² After Atatürk's death in 1938, İsmet İnönü, who had served as prime minister since 1923, became president and pursued the path of authoritarian modernization.⁴³

The CHP governments under Atatürk and İnönü placed a strong emphasis on economic development through state-led industrialization and the extension of bureaucratic rule to the economic sphere.⁴⁴ Economic policies at the time aimed at productive growth through industrialization. Furthermore, the establishment of a new Muslim bourgeoisie was facilitated. A new class of entrepreneurs which stemmed from the ruling elite built a coalition with the Kemalist bureaucracy. The necessary means to finance economic policies were accumulated from urban artisans and the peasantry. However, at the beginning of World War II, the success of the etatist economic policies came to an end. Industrial and agricultural production declined significantly, while consumer prices exploded and the economy declined sharply (Keyder 1987, 91-117).

In consequence, during the 1940s, the CHP became increasingly unpopular among the Turkish population. Living standards among the rural population in particular, had shown little or no improvement, and high taxes as well as unpopular cultural reforms provoked resistance against the central state (Zürcher 2004, 206-08).⁴⁵ Furthermore, in light of growing ethnic and social tensions, a democratic multi-party system had become a favorable alternative for the industrial bourgeoisie (Keyder 1987, 114).⁴⁶ In 1946, a group of former CHP members led by Adnan Menderes separated

⁴² In 1930, the Swiss civil code was adopted, which officially eliminated Islamic law as an organizing framework for Turkish society. In 1931, a new press law allowed the government to shut down newspapers and magazines. In 1933, a university reform resulted in the expulsion of two-thirds of the teaching staff at Istanbul University, the only Turkish university at the time (Lewis 1961, 272).

⁴³ For an overview, see: Lewis 1961, 294-319; Zürcher 2004, 185-205.

⁴⁴ In 1933, a five-year plan was announced to boost Turkish industry. Large-scale state enterprises were established and private industrial businesses were granted cheap credit. Furthermore, the government supported cartel-like industrial associations that internally avoided overproduction and regulated prices within specific sectors. The manufacturing output of Turkish firms doubled between 1932 and 1939 and Turkey registered an export surplus between 1930 and 1938 (Keyder 1987, 102). Turkey's Gross National Product increased significantly. However, only approximately one-fourth of the industrial businesses profited from the new regulations. At the same time, 74.2 percent of all companies founded between 1931 and 1940 were established by members of the bureaucracy (Ibid., 106).

⁴⁵ Despite the loss of 20 percent of the agricultural labor force and large parts of the Christian merchant class, the Turkish economy during the early Republican years built largely on the export of surpluses of agricultural products and raw materials. This was made possible by the rise of foreign merchants backed by European capital as well as a Muslim bourgeoisie which had slowly evolved under the protection of the Young Turk rule. While agriculture recovered quickly, industrial production in Turkey was in its infancy. As the 1927 census shows, approx. 250,000 workers were employed in one of the 65,000 productive businesses at that time. Nevertheless, only 2,822 of those businesses used mechanical power (Zürcher 2004, 196).

⁴⁶ The old urban merchant class, mostly consisting of members of the non-Muslim minorities, functioned as a link between the European powers and the Turkish market. Germany, especially, was in desperate need of Turkish raw materials and foodstuffs. However, in 1942, the Turkish government introduced a wealth tax (*varlık vergisi*)

from the ruling party and founded the Democratic Party (*Demokrat Parti*, DP). Although early elections prevented the new party's success, the CHP's political authority was now challenged by a parliamentary opposition.

The omnipresence of the Turkish state in the political and economic sphere stood in sharp contrast to its absence in the realm of welfare provision up to the end of World War II. Social policies almost exclusively targeted military personnel and civil servants.⁴⁷ The vast majority of the population lived in rural areas, with most Turks employed in agriculture or small-scale workshops, meaning they were not affected by labor market and social security reforms (Keyder 1987, 118). Only a small number of legal changes focused on state employees and blue-collar workers in industrial workplaces (Buğra 2007, 42).⁴⁸

It was not before the mid 1940s that a number of legal reforms were introduced, which laid the institutional groundwork for the Turkish social security system.⁴⁹ In 1945, the Labor Insurance

imposed primarily on the minorities. Christian and Jewish citizens were expected to pay taxes at rates ten times higher than that of Muslims citizens. In consequence, many established businesses went bankrupt and Western powers lost confidence in the Turkish state and economy. The oppression of the Christian and Jewish urban merchant class also severed the coalition between the Kemalist bureaucracy and the Muslim industrialists. Although the Muslim industrialists had not openly opposed the central state's drastic measures against non-Muslim merchants, it revealed their own vulnerability, as well as political dependence on the Kemalist bureaucracy (Keyder 1987, 112-15).

⁴⁷ In 1930, the Military and Civil Retirement Law (*Askeri ve Mülki Tekaüt Kanunu*) united the Ottoman retirement funds for civil servants and military personnel under one law. These funds had been established in the mid 19th century and covered pension and disability insurance for military personnel and civil servants. From the beginning of the 20th century onwards, similar funds were established for trade and craftsmanship, as well as industrial workers. In 1851, the Ministry for Orphans (*Emval-i Eytam Nezareti*) and the so-called Orphan Funds (*Eytam Sandığı*) were established, providing financial assistance to orphans, widows and the mentally ill. In 1866, the Military Pension Fund (*Askerî Tekaüd Sandığı*) was established. In 1881, a pension fund for civil employees was also established. From the mid 19th century onwards, the Ottoman state created various retirement funds (*Tekaüt Sandığı*) for civil servants and military personnel. Furthermore, the state took responsibility for their surviving dependants. By the end of the 19th century a complex system of retirement funds had been established that would socially secure civil servants and military personnel until the creation of the Turkish social security system after World War II (Fişek et al. 1998, 10-11).

⁴⁸ The Law of Obligations (*Borçlar Kanunu*) of 1926 required employers to take necessary measures to protect their workers' health and to prevent work accidents. Furthermore, it gave workers with long-term contracts the right to apply for benefits in case they fell sick or were drafted to military service. However, it did not legally oblige employers to provide social insurance for their employees. Where workers were covered by social insurance, employers and employees paid equal insurance premiums. If an employee was unable to pay his premiums the employer was absolved of his duty to continue paying his contribution. In 1936, the new Labor Law (*İş Kanunu*) regulated the working conditions of industrial workers. However, only half a million of the total labor force of 14.5 million were covered by the law (Buğra 2007, 42).

In 1930, the Public Health Law (*Umumî Hıfzıssıhha Kanunu*) set general hygiene and work safety standards. Child labor in industrial workplaces was declared illegal, working hours were regulated and mothers were obliged to take six weeks maternity leave and were exempt from physical labor for three months. Furthermore, employers running workplaces with more than 50 employees were obliged to hire at least one physician responsible for workers' health. Industrial workplaces employing between 100 and 500 employees were obliged to run an infirmary and those with more than 500 employees had to open a hospital providing at least one bed per hundred workers. However, due to a lack of inspections the law was rarely implemented (Fişek et al. 1998, 12).

⁴⁹ In 1945, the Work Accidents, Occupational Diseases, and Maternity Insurances Law (*İş Kazalarıyla Meslek Hastalıkları ve Analık Sigortaları hakkındaki Kanunu*) and the Labor Insurance Institution Law (*İşçi Sigortaları*

Institution (*İşçi Sigortaları Kurumu*, İSK) was established as a social insurance fund for blue-collar workers which included healthcare insurance. While social insurance agencies in continental Europe functioned as a blueprint, significant institutional differences existed between the Turkish health insurance system and its counterparts in corporatist welfare states. The Agency was formally established in 1945 with the Labor Insurance Institution Law (*İşçi Sigortaları Kurumu Kanunu*) as a legal personality subjected to private law and financially and administratively autonomous. However, unlike insurance funds in Central Europe, it was subordinate to the Ministry of Labor and strictly controlled by the central authorities.⁵⁰ Accordingly, hierarchical state control over societal actors, which was a part of welfare and healthcare provision since the early 19th century, can also be seen in the institutional origins of the Turkish social insurance system.

State dominance in the realm of social policy was complemented by a weak level of organization and absence of power resources among the social classes. Similar to the experience of other late-industrializing countries, social policies in the early Turkish Republic were an integral part of the etatist project of modernization and nation-building and not the outcome of conflicts between organized labor and capital (compare Gough and Wood 2004, 1-8). In fact, in the Turkish context class relationships in the early 20th century were characterized by the late emergence of an industrial working class on the one hand, and the expulsion of the non-Muslim bourgeoisie during and after World War I, as well as the absence of large landownership, on the other. These conditions allowed the central state to pursue its modernization project more or less unchallenged by social groups and manifested in hierarchical state control over the institutions of the welfare state (Keyder 1987, 2).

The health status of Turkey's war-ridden population was bleak. Life expectancy between 1935 and 1940 was still as low as 35 and the child mortality rate stood at 27 percent (Günel 2008, 162). The overwhelming majority of the Turkish population had no access to professional healthcare.⁵¹ However, due to the absence of social groups with power resources, the pressure on government to further implement policies to improve the population's health status was limited. In the first decades after it was established, the MoH focused almost exclusively on disease containment and the regulation of preventive healthcare. Furthermore, while abortion, sterilization, and the sale of contraceptives were declared illegal, the Ministry put strong efforts into the promotion of birth rates and the health of

Kurumu Kanunu) were passed by the Grand Assembly. In 1945, the Ministry of Labor (*Çalışma Bakanlığı*) was founded. In 1949, social insurance for workers was extended to old age insurance with the Old Age Insurance Law (*İhtiyarlık Sigortası Kanununu*) (Ibid., 12).

⁵⁰ Officially a state institution, the agency was designed as a legal personality subjected to private law and financially and administratively autonomous. However, its general director and most of the members of its executive organs were selected by state ministries. Only a fraction was appointed by employers associations or labor unions. Furthermore, the agency was staffed by civil servants.

⁵¹ According to the 1927 census, more than 80 percent of Turkey's 13.65 million citizens lived in rural areas (Keyder 1987). In 1928, 1,078 physicians, 130 female nurses, 1,059 male nurses, so called health officers, and 377 midwives were active in Turkey (TurkStat 2009, 54).

infants and mothers.⁵² Accordingly, the MoH's main responsibilities were the control of hygiene and medical standards, the appointment of medical staff to and the supervision of medical and public institutions, the administration of medical education, the production of medical materials and pharmaceuticals, as well as the preparation of statistics (Ağartan 2008, 138-41; Günel 2008, 165-70).⁵³ The MoH only reluctantly engaged in curative care provision. In 1924, the Ministry erected so-called Model Hospitals (*numune hastaneleri*) in four different cities in order to serve as examples for municipality-owned facilities (Ibid., 149). Additionally, it supervised infectious disease hospitals as well as facilities for the mentally ill and disabled. However, three out of four hospitals at the time were either run by the local authorities or by non-government actors, such as minority foundations and congregations.⁵⁴ In order to tackle public health issues, the Ministry began to appoint State Physicians to so-called Examination and Treatment Houses (*muayene ve tedavi evleri*) in larger cities, as well as Mobile Physicians (*seyyar hekimlik*) to reach more isolated parts of the country. However, these health professionals were mostly engaged with preventive care and vaccination programs and their impact can be considered limited (Aydın 2002, 36-39). While approximately 300 Examination and Treatment Houses had been established by 1950, many facilities were understaffed and badly equipped (Ağartan 2008, 139-40). From 1949 onwards, the Workers Insurance Agency built its own healthcare facilities, mostly in urban areas, to provide its insurants with better services.⁵⁵ This is noteworthy as a purchaser and provider split, which is typical for the health insurance systems in corporatist welfare states, did not develop in Turkey.

In sum, the health policies of the early Turkish Republic were part of a larger project of nation-building and modernization. What is distinctive about the emergence of the Turkish welfare state is the absence of social groups with power resources and, in consequence, the unchallenged position of the central government which manifested in the hierarchical control over the social insurance agency and healthcare providers. At the same time, healthcare was not understood as a social right of individual

⁵² Birthing services in public hospitals were declared free of charge and women were granted three weeks maternal leave.

⁵³ It appears striking that the control of curative care institutions lay not in the hands of the Healthcare Department but in those of the Social Assistance Department of the ministry.

⁵⁴ The central state delegated curative healthcare provision to regional authorities. The Village Law (*Köy Kanunu*) of 1924 obliged every village with less than 2,000 inhabitants to appoint a so-called Health Guard (*sağlık kurucusu*) and send him off to training at the central authority. However, in 1925, 6,278 out of a total of 8,433 beds were managed either by local authorities or were in private hands (Aydın 2002, 37). As municipalities were under the strict control of the central government at the time, it is difficult to determine to which degree hospitals run by local authorities acted autonomously.

⁵⁵ One of the most significant characteristics of the health system was the shortage of healthcare professionals. While the state took only reluctant steps to train new doctors it had almost completely neglected the education of nurses and midwives. Before 1960, there was only one faculty of medicine and an affiliated school of midwifery. Furthermore, a single nursery school was run by the Red Crescent and three schools for health officers (*sağlık memuru*) were run by the MoH to train male nurses. During World War II, as a reaction to the dramatic lack of health personnel, the Ministry of Education trained villagers as health officers and nurses (Ağartan 2008, 140).

citizens. Instead, based on the premise that economic development requires a healthy population, healthcare policies in the first decades of the Turkish Republic focused exclusively on preventive healthcare provision. Access to curative care was interlinked with occupational status and the patient's role in the project of state-led modernization. While some privileged groups were favored by social policies and industrial workers benefitted from a newly established social security institution that made curative care more accessible by the end of World War II, for the vast majority of the Turkish population, healthcare was provided as a commodity, charity, or informally by family members.

2.3 The rise of Turkey's democracy (1950-1960) – The state emerges as a provider of curative care

In the first free elections of 1950, the DP won the vast majority of seats in parliament, effectively marginalizing the CHP's influence after 27 years in power. Although the outcome of the election has to be read as a shift of power within the old elite, the existing alliance between the government, military, bureaucracy, and urban entrepreneurship in favor of state-led industrialization and authoritarian modernization came to an end. Under the constant threat of military intervention, the Menderes government was faced with the challenge of placating the military and old elite, which dominated the state institutions and, at the same time, its mostly rural and conservative electorate. The DP's strategy to consolidate power focused on gaining popular support through economic reforms and the reversal of cultural and religious policies of the early Republican era.⁵⁶

In the years to come, free market policies, subsidized agricultural development, and large infrastructure projects financed by foreign loans, led to a significant rise in economic growth.⁵⁷ Backed

⁵⁶ The Turkish call to prayer was changed back to Arabic, religious teaching was allowed at public schools, and thousands of mosques that had been built throughout the country were staffed with state controlled clerics. However, the Menderes government never put the fundamentals of the secularist republic into question. It strictly opposed any ambitions to reintroduce Islamic law and promoted the personal cult that had evolved around Atatürk and his political heritage. Just like their predecessors, the DP's definition of secularism did not mean separation of church and state but the "subjugation and integration of religion into the state bureaucracy" (Zürcher 2004, 233). For an overview of the DP era see: Zürcher 2004, 221-41; Kalaycıoğlu 2005, 74-90; Keyder 1987, 117-40; Owen and Pamuk 1998, 117; Sunar 1990; 1994.

⁵⁷ It has to be outlined that important steps toward a more liberal economy had already been taken during the last years of the İnönü era, in line with the incorporation of Turkey into the Western alliance. In order to qualify for aid from the Marshall Fund and to attract private American capital, a number of measures were taken, such as a greater emphasis on agricultural development, private enterprise, and a more liberal foreign exchange and trade regime. However, once the DP came to power it continued this path with great enthusiasm. In the eyes of the Menderes government Turkey's economic future and its role in the global market lay in the export of agricultural goods. The government began distributing land to small scale farmers and between 1950 and 1960, 312,000 families received land, reducing the percentage of village families without land from 16 percent to 10 percent during the same period (Keyder 1987, 126).

While the government used land distribution to strengthen small farm ownership throughout Anatolia it also took measures to modernize large- and medium-sized farms. The DP used Marshall Plan funds to import a large amount of agricultural machinery. These were purchased mostly by more prosperous farmers which were offered cheap credit by the Agricultural Bank. While barely one thousand tractors were in use in Turkey in 1946,

by its economic success and public support, the DP felt empowered to take measures against the bureaucratic elite. Resorting to authoritarian politics, the Menderes government tried to eliminate its political opposition.⁵⁸ These policies did not undermine DP's popular support and the party was re-elected in the national elections of 1954 and 1957. However, they further alienated members of the bureaucracy, urban elite, and army. Tensions started to increase, and on May 27, 1960, the army used the political turmoil in the aftermath of the Istanbul Pogrom against Christian minorities as a pretext to carry out a coup d'état. Menderes was put on trial and sentenced to death.⁵⁹

During the decade of DP rule geographical and social mobility of the rural population increased significantly.⁶⁰ A boom in urban industrial production that was boosted by protectionist policies in the second half of the 1950s, manifested in growing entrepreneurial activity in western urban centers.⁶¹ While the rise of Turkish industry led to a significant increase in industrial production, the level of organized labor remained weak.⁶² Additionally, most rural migrants could not find employment in the industrial sector and worked in services and small-scale workshops (Keyder 1987, 136-37). This group settled mostly in the Turkish version of shantytowns (*gecekondu mahallesi*), which would play a significant role in the provision of welfare and neighborhood support in the decades to come (Eroğlu 2011).

While the Menderes government did little to improve the living conditions of the new urban poor through social assistance, it delegated significant resources to the healthcare system. New hospitals, as well as university departments and schools to train health professionals, were established and existing facilities expanded. At the same time, health centers were created which provided preventive and curative outpatient care to the rural population. Between 1950 and 1960, the number of hospitals

that number had increased to 43,000 in 1955. As a consequence, cultivated land increased from 9.5 million hectares to 14.2 million hectares during the same period. The result was a massive increase in agricultural production (Ibid., 130).

⁵⁸ Press freedom was restricted, the economic base of the CHP was attacked, a new electoral law was passed forcing opposition parties to form political alliances, and critical civil servants in the bureaucracy, judiciary, and academic system were forced to retire (Zürcher 2004, 229-32).

⁵⁹ On 6 September 1955, ethnic riots broke out in Istanbul and over 5,000 houses, most of which were owned by Greek families, were ransacked. The pogrom was triggered by news that a Greek citizen had placed a bomb in Atatürk's house of birth in Thessaloniki. In the aftermath of the riots the Menderes government had to take responsibility for the events and the cabinet was reshuffled.

⁶⁰ The expansion of infrastructure and means of transportation made it possible and affordable for the rural population to move to the urban centers to look for employment. Large numbers of peasants profited from the public distribution of land, and the mechanization of labor allowed them to send family members off to the cities. At the same time, the workforce of many seasonal sharecroppers became dispensable and a first wave of approximately 1.5 million migrants flocked to Turkish cities between 1950 and 1960. During the 1950s, the urban population increased from 19 to 26 percent and the population of the four largest cities increased by 75 percent (Keyder 1987, 137).

⁶¹ It was the accumulation of capital during the 1950s that enabled the establishment of most of today's major Turkish companies that dominated the domestic market until the 1990s.

⁶² In 1950, only one-fifth of the 375,000 Turkish workers were members of trade unions. In 1952, the first trade union confederation, Türk-İş, was established but its resources and political influence remained marginal (Zürcher 2004, 227).

increased from 201 to 566 and the number of health centers from 22 to 283. During the same period, official numbers suggest that the doctor per capita ratio fell from 6,890 to 2,799 (TurkStat 2009, 50-62). Simultaneously, public health policies that had been implemented over the previous decades finally yielded visible results. Cases of epidemic diseases, such as typhus, tuberculosis, and malaria, decreased significantly.⁶³

Despite these efforts to improve curative care standards, the quality of public healthcare remained low. Simultaneously, improvements in infrastructure and the availability of pharmaceuticals and technology led to a rising demand for services. In consequence, many physicians opened private practices especially in urban areas. Many of these physicians worked part-time in the private sector and kept their positions in state-owned facilities (Günel 2008, 186).

The shift from public to curative care during the DP era was costly. While social insurance schemes covered only a small minority, policy makers at the time stressed the incapacity of the Turkish state to fully finance the healthcare system through taxes. Instead, the government decided to resort to households to finance the inpatient care. In 1955, the government passed the Regulation on Hospitals (*Hastaneler Talimatnamesi*) which brought significant changes with regard to access to and financing of hospital care, and institutionalized the role of households in healthcare financing. The regulation set the framework for secondary care provision and service fees. Curative care provided in public hospitals was only free of charge for specific groups in society, such as pregnant women living in poor households and patients with infectious diseases. The expenses of civil servants were paid for by the institutions they were employed by and, after 1951, the Social Insurance Institution covered the health costs of formal sector employees (Ibid., 183-85). The vast majority of the Turkish population, however, which was working in the agriculture or informal sectors, had to pay for hospital services out-of-pocket.

The government's new emphasis on curative care also implied a new role for the state in healthcare regulation. In 1954, hospitals that had been previously run by the municipalities and provinces were centralized under the MoH and subsequently financed from the central budget (Ibid., 180). The impact of this reform on hospital management and financing is difficult to assess as municipalities had been under strict political and fiscal control of the central government since the foundation of the Turkish Republic. Nevertheless, it can be assumed that the centralization of hospital regulation in the MoH and the strengthening of its role in curative care led to more direct control of the state in inpatient care provision. However, more research is necessary to verify this claim.

⁶³ For an overview see: Ağartan 2008, 162-68; Günel 2008, 175-88.

From today's perspective, the Menderes government had a strong impact on the trajectory of Turkish politics and in particular, served as a reference for the liberal conservative governments of the 1980s and 2000s. As İlkay Sunar puts it:

The Demokrat Party shaped deeply the nature and course of post-authoritarian politics in Turkey. The clientelist incorporation of the rural population, the patronage-induced private initiative, and the great haphazard societal dynamism fueled by populism – all of these have not only outlived the DP, but have become permanent features of center-right politics, dominant in Turkey since 1950 (Sunar 1990, 753).

With regard to health policies, the DP had also entered uncharted waters. In particular, the Menderes government put a new emphasis on the state's responsibility for curative care provision. The number of state-run curative outpatient and inpatient care facilities across the country increased significantly and the central state established itself as the key financing agent and regulator of healthcare.

However, the DP's reforms went only part way to establishing a universal healthcare system. In congruence to previous decades, public policies continued to protect the interests of specific occupational groups, in particular, civil servants and formal sector employees who had access to healthcare through government and social insurance schemes. At the same time, after the hospital sector reform of 1955, the vast majority of Turks, namely those that worked in agriculture, the informal sector, and the self-employed, were legally obliged to pay for secondary care out-of-pocket. Accordingly, under DP rule, the importance of households in healthcare financing was strengthened. While the family had been the key actor in healthcare financing and provision in previous decades, government regulations during the DP era further institutionalized this role. At the same time, public authorities did little to regulate for-profit providers of outpatient curative care which gained importance in the industrial cities of western Turkey, and the capital Ankara. They were free to set the fees for their services which further increased the financial burden on households.

2.4 Contested national developmentalism – The establishment of a two-tier healthcare system (1960-1980)

Military rule ended in 1961 and a new constitution was approved through a national referendum. While the old constitution of 1924 allowed for the abuse of political power through an uncontrolled unicameral legislature and an electoral system that disadvantaged the opposition, the new constitution put a strong emphasis on checks and balances. At the same time, however, the military institutionalized its political influence with the creation of the National Security Council (*Milli Güvenlik*

Kurumu), which entitled the military to interfere in government affairs and shaped civil-military relations for the decades to come (Kalaycıoğlu 2005, 93-99; Zürcher 2004, 241-77).⁶⁴

The first half of the 1960s was characterized by alternating coalition governments in which İnönü and his CHP played a strong role. In the elections of 1965, the successor of the DP, the Justice Party (*Adalet Partisi*, AP) led by the charismatic Süleyman Demirel, won an absolute majority of seats in parliament and the CHP's role was again marginalized (Ibid., 250).

In retrospect, Turkey's political landscape changed tremendously during the 1960s with new political parties entering the stage. A communist party was able to participate in an election for the first time, while on the extreme right, nationalists organized under the Nationalist Movement Party (*Milliyetçi Hareket Partisi*, MHP), and with the Islamist National Order Party (*Milli Nizam Partisi*, MNP) led by Necmettin Erbakan, political Islam also entered the Turkish party system. Simultaneously, Turkey witnessed a dramatic radicalization of politics. Terrorist attacks and violence between political groups led to a second military intervention in 1971. The generals installed a new government and declared martial law. Turkey stepped into another era of authoritarian rule (Kalaycıoğlu 2005, 101-05; Zürcher 2004, 252-58).⁶⁵

Eventually, the army withdrew from politics and national elections were held in October 1973. However, in the years to come, a series of weak coalition governments failed to restore political stability, resulting in a rise in street violence. Some 1,000 to 1,500 people were killed in politically-motivated clashes between 1977 and 1979 (Zürcher 2004, 263). The situation deteriorated further when the Kurdish Workers' Party (PKK), founded by Abdullah Öcalan in 1978, thrust the Kurdish question back onto the political agenda by carrying out terrorist attacks. In light of the scale of political violence, the threat of Kurdish separatism, economic crises, and the inability of political rulers to tackle these challenges, it was no surprise that large parts of the urban middle class hailed the Turkish army when it overthrew the government for a third time on 12 October 1980.⁶⁶

In economic terms, the political forces behind the 1961 constitution, namely the military, bureaucracy, and academia, implemented policies that significantly recalibrated the Turkish model of capitalism and the country entered a period of Import Substitution Industrialization (ISI). In order to develop a

⁶⁴ The legislative was divided into two chambers: the National Assembly and the Senate. An independent constitutional court was established. Political parties, universities, and the media were granted extensive freedoms. Additionally, a new electoral system based on the d'Hondt method of proportional representation was introduced. At the same time, the new constitution banned party organizations below district level and as such restricted popular participation in politics. Party leaders would gain significant importance in the Turkish political system as they could remove ministers belonging to their party at will (Kalaycıoğlu 2005, 102).

⁶⁵ While the 1961 constitution was preserved, new amendments severely limited civil liberties as well as the freedom of press and universities. The left in particular was targeted by the junta. The communist Workers Party was closed down and thousands were arrested. Similarly, after being banned by the Constitutional Court in 1970, the MNP was reorganized under the National Salvation Party (*Milli Selamet Partisi*, MSP) also led by Erbakan (Ibid., 105-07).

⁶⁶ For an historical overview of the 1970s see: Ibid., 105-24; Zürcher 2004, 258-77.

globally competitive industry in the long run, the State Planning Organization (*Devlet Planlama Teşkilatı*) was set up as an institution for macroeconomic steering, and Turkish industry was completely protected from international competition (Sunar 1990; 1994).

In the short run, the ISI policies were a tremendous success and the Turkish economy boomed. However, political authorities failed to create incentives for industrialists to invest in their products and increase their sophistication and competitiveness. Turkey was, therefore, unable to transform from an inward-looking economy based on ISI policies to a competitive market economy, and the Turkish industrial sector continued to depend on the import of technology, machinery, and production goods from Western Europe.⁶⁷ During the 1960s and early 1970s, these imports were financed mostly through agricultural exports and remittances from Turkish workers abroad. From the 1970s onwards, the central bank had to borrow foreign loans keep the value of the Turkish lira artificially high and imports cheap. After an outflow of foreign capital in the aftermath of the oil crisis, the system that financed ISI collapsed and the International Monetary Fund (IMF) stepped in, launching a full-scale stabilization program. However, in 1979, in the course of the second oil crisis, the Turkish economy collapsed, further destabilizing the political situation and contributing to the conditions that led to Turkey's third military coup a year later (Owen and Pamuk 1998, 114).

Two groups in particular profited from the new economic policies of the 1960s: the industrial bourgeoisie and the urban working class. Measures were taken to integrate a new class of industrial labor into the system and create a domestic market through the redistribution of capital.⁶⁸ However, higher wages and new social rights almost exclusively favored workers in large-scale industries located in Istanbul and Izmir as well as the Adana-Mersin region.⁶⁹ During this process, trade unions gained

⁶⁷ As Albert O. Hirschmann points out, the successful implementation of ISI, and constitution of a domestic market, depends to a large degree on the independence of political authorities from the industrial bourgeoisie. First, redistribution between capital and labor in the form of high wages is necessary to create a sufficient demand for consumer goods in the domestic market. Second, in a protected market economy, little incentives are given for the domestic industrial bourgeoisie to invest in research and developing globally competitive products (Hirschmann 1968).

⁶⁸ The State Planning Office was established to allocate public resources and to regulate access to foreign currency. At the same time, five-year-plans were made in order to coordinate public investments and industrial production. Especially during the years of the AP government, State Economic Enterprises produced low price inputs for the private sector, while large family holdings producing consumer goods for the Turkish market flourished under state protection. As market mechanisms were annulled, the allocation of resources was in the hands of the top administrative level which favored the interests of the industrial bourgeoisie (Keyder 1987, 168-77).

⁶⁹ Workers in small industries and in traditional workshops were still exempted from the right to strike or collective bargaining and earned less than their colleagues in bigger industries. The average wage of workers in companies with less than 10 employees was around 40 percent of the wages of workers in companies employing more than 100 workers. It can be assumed that the wages of uninsured employees and of the underaged, which are not included in the official statistics, were even lower (ibid., 175).

importance.⁷⁰ Nevertheless, the Turkish left could neither position itself so it had any influence in the policy making process, nor could it challenge the predominant tenets of Kemalist populism with class-based concepts and political demands. Instead, the political left underwent an internal division that has persisted to this day (Mello 2010; İşıklı 1987).

At the same time, Turkey's demographics were changing rapidly. Between 1950 and 1980, the population grew from 21 to 44.7 million (Keyder and Öncü 1993, 16). The urban population increased from 31.9 percent in 1960 to 43.9 percent in 1980 (Buğra 2007, 43). *Gecekondu* settlements sprang up all over major cities and with only a minority of rural migrants able to find employment in industry, the majority were forced into the informal sector (Ibid., 44; Buğra and Keyder 2005, 18).

With regard to social policy, the new constitution of 1961 emphasized the state's responsibility to its citizens in terms of providing social welfare. In the realm of healthcare, decision-makers took this responsibility seriously. In 1961, the Socialization of Health Services Law (*Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkındaki Kanun*) was passed that on paper, at least, created a National Health System in Turkey and legally entitled all citizens to equal and free access to the healthcare system. While the state had already taken more responsibility in curative care provision during the DP era, it now saw itself as the key actor in healthcare financing, provision, and regulation.

The reforms of the era were ideologically framed by national developmentalism. Economic growth and social justice were perceived as integral parts of Turkey's democratic development (Owen and Pamuk 1998, 106). Inspired by developments in mature European welfare states, the developmentalist ideology was complemented by the idea of health as a fundamental human right. In this logic, health was a citizen's right and healthcare provision became the state's responsibility toward the individual. At the same time, population planning was perceived as an elementary part of economic and social development. In light of steady population growth, the government broke with the pronatalist policies of previous decades and promoted birth control and family planning (Ağartan 2008, 132-33).

However, the Socialization of Health Services Law was only partially implemented. Due to a lack of resources and political commitment, its impact was limited to the establishment of a network of facilities run by the MoH across the country, providing free public and outpatient curative care.

The capabilities of these facilities were limited and regional disparities in the distribution of facilities and healthcare professionals resulted in significant inequalities in the access to curative healthcare. In consequence, the tax-funded facilities run by the MoH provided mostly preventive and outpatient

⁷⁰ The constitution of 1961 legalized unionization and collective bargaining. In 1963, the Turkish parliament passed a law which legalized strikes (Mango 2004, 68). The workforce in the state-protected industrial sector increased significantly and soon constituted the majority of industrial labor. The State Economic Enterprises alone employed 700,000 workers by the end of the 1970s. In consequence, the number of organized workers increased steadily. By the late 1970s, Turk-İş had between one and 1.3 million members. A second umbrella organization for trade unions was established, the Confederation of Revolutionary Trade Unions (*Devrimci İşçi Sendikaları Konfederasyonu*, DİSK) which had between 300,000 and 400,000 members (Zürcher 2004, 273).

curative care to the urban poor and rural population. Civil servants and formal sector employees covered by social insurance schemes continued to visit the outpatient departments of state-owned hospital, while wealthier citizens preferred to visit the outpatient departments of private hospitals or private practices to receive outpatient care (MoH 2003b, 49-59).

Aside from insufficient funding and a lack of political commitment, institutional constraints also prevented a comprehensive healthcare policy reform. The social insurance institutions, as well as their members, strongly opposed the reorganization of the Turkish healthcare system (Ağartan 2008, 169). During the 1960s and 1970s, a number of reforms led to the consolidation of the social insurance system and, in congruence to the economic policies of the time, it was mostly industrial workers and civil servants in urban Turkey that benefited from these reforms. In 1964, the İSK was reorganized under the Social Insurance Agency (*Sosyal Sigortalar Kurumu*, SSK) and its own network of outpatient and inpatient care facilities was further expanded as part of the new Social Insurance Law (*Sosyal Sigortalar Kanunu*). In 1971, the Law on the Social Insurance Institution for Tradesmen and Craftsmen and Other Self-Employed Workers (*Esnaf ve Sanatkârlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu*), hereafter referred to as *Bağ-Kur*, was established, at first as a pension fund, and from 1981 onwards as a health insurance scheme.

In sum, the rise of a new capitalist paradigm of national developmentalism during the 1960s introduced a formal redefinition of the state's role in healthcare financing, provision, and regulation. However, the initial reform, which comprised a comprehensive restructuring of the healthcare system toward a National Health Service based on the British model, was only partially implemented. At the same time, the existing social insurance system was further strengthened and extended to new occupational groups.

In consequence, a two-tier healthcare system was consolidated during the 1960s and 1970s. Patients that belonged to occupational groups that were covered by the health insurance system had privileged access to curative outpatient and inpatient care facilities. Those without public health insurance had free access to preventive and curative outpatient care, which was provided in a network of tax-funded facilities. These facilities, however, lacked the necessary funding and personnel and the quality of services was poor. In terms of inpatient care, those without public health insurance had to continue to pay for services out-of-pocket. Consequently, large segments of society continued to rely on their household's capacity and willingness to pay for medical services out-of-pocket.

2.5 Liberal conservatism and the rise of healthcare markets (1980 to 2002)

The junta consolidated all executive and legislative power into their hands: The constitution of 1961 was suspended, the parliament dissolved, and all political parties - even the CHP which was founded by

Atatürk - were banned from politics. Any political opposition was suppressed with brutal force. Tens of thousands of political activists, mostly leftist but also Islamists and nationalists, were imprisoned and many were tortured. Thousands migrated to Western and Northern Europe to escape state persecution (Zürcher 2004, 241-78; Öktem 2011, 58-65).

In contrast to previous coups, the generals only reluctantly transferred political power back to a civilian government. On 7 November 1982, a new constitution was put to vote and approved by 92 percent of the electorate but the document stood in sharp contrast to its liberal predecessor and was designed to bring political stability at the cost of democracy and balance of powers.⁷¹ At the same time, the political role of the military was consolidated with the expansion of the authority of the National Security Council (Kalaycıoğlu 2005, 126-27).

On 6 November 1983, national elections were held but only three parties were allowed to run.⁷² The winner was the Motherland Party (*Anavatan Partisi*, ANAP), which gained the support of a broad coalition of social groups, including parts of the industrial bourgeoisie, the peasantry, petty producers in Anatolia, but also Islamist and nationalist forces. With substantial financial support from the Bretton Woods institutions, the ANAP government headed by Turgut Özal transformed the protectionist ISI system into a market-driven and export-oriented economy and between 1979 to 1989 merchandise exports grew from 2.3 billion to 11.7 billion US dollars (Arıcanlı and Rodrik 1990, 1347). At the same time, it secured popular support through a politics based on a synthesis of Turkish nationalism and religious conservatism rooted in Sunni Islam. In the following years, under the watchful eyes of the Kemalist secular elite, a new coalition of liberal conservative government and non-government actors emerged that increasingly aspired toward political, social, and cultural hegemony.⁷³

Small and medium-sized family businesses located in central Turkey, the so-called Anatolian Tigers, gained importance and a new class of entrepreneurs emerged that created the socio-economic basis for the rise of political Islam in Turkey (European Stability Initiative 2005; Filiztekin and Tunalı 1999; Yavuz 2003, 88). However, the advent of economic liberalism did not put an end to government intervention in economic affairs.

⁷¹ Political power was centralized in the executive and the legislative was weakened. The Senate was abolished and the Great National Assembly returned to its pre-1961 unicameral form. The presidency was granted arbitrary powers and turned into the top executive power (Kalaycıoğlu 2005, 129-31).

⁷² The Party of Nationalist Democracy (*Milliyetçi Demokrasi Partisi*, MDP), which was closely linked to the junta, the Populist Party (*Halkçı Party*, HP), gathering the Kemalist wing of the CHP, and the ANAP.

⁷³ In congruence to the DP era, the government's attempts to gain public support by building thousands of new mosques and allowing religious content in television shows and school books, together with a growing demand for the lifting of the headscarf ban at Turkish universities, put members of the secularist urban intelligentsia into a state of panic. Kerem Öktem describes this nationalist-Islamic synthesis as an "eclectic mix of authoritarian, if incoherent, ideologies ranging from Turkish ethno-racial nationalism, Islamist supremacism and Ottomanism to Kemalist authoritarianism" (Öktem 2011, 62).

[W]e witnessed the emergence of a new vintage of politically created business actors who enjoyed favors defined by the new mechanisms of government intervention and deployed within networks that draw on cultural resources informed by religious identity (Buğra and Savaşkan 2014, 19).

The liberal conservative coalition introduced a new paradigm of capitalist development which stood in sharp contrast to traditional national developmentalism. While industrial relations and social policies in previous decades, at least to a certain degree, aimed at corporatist interest representation and state protectionism over occupational groups, the new political discourse focused on social equity and made strong reference to religious norms and private benevolence (Göçmen Yeginoğlu 2010, 88-91).

The constitution of 1982 had reintroduced authoritarian government structures that now worked in favor of the new liberal conservative government. Trade unions could not pursue any political activities and were forbidden from having any kind of affiliation to political parties. At the same time, the high threshold of 10 percent for national elections marginalized the influence of new political parties. While some civil liberties, such as the right to speak Kurdish in public or to appeal to the European Commission on Human Rights, were granted, political and ethnic conflicts escalated. In 1984, an open war between Kurdish separatists and Turkish security forces broke out, which would continue for almost two decades and cost the lives of tens of thousands. While the 1983 elections had put an end to military rule in most of Turkey, the Kurdish southeast remained under emergency rule. The de facto existence of two political systems in the 1980s and 1990s further widened the socio-economic gap between the Kurdish regions and the rest of the country, in particular, the metropolis in the industrialized western parts (Öktem 2011, 88-95; Zürcher 2004, 316-23).

In the elections of 1987, the ANAP won an absolute majority of seats in parliament for the second time. However, by the end of the decade its popular support had faded in the wake of increasing economic problems and corruption scandals, some of which led to Özal and his closer family. While Özal managed to safeguard his personal power by successfully running for the presidency in November 1989, the ANAP lost its majority during the elections of 1991 and Turkey stepped into the “lost decade of Turkish politics”, which was characterized by a series of coalition governments, the absence of significant political reforms, economic crises, and the ongoing war in the Kurdish southeast. At the same time, tensions between the secular elite and political Islamists increased after the Islamist Welfare Party (*Refah Partisi*, RP) led by Necmettin Erbakan, became the strongest party during the 1995 elections. On 28 February 1997, after the RP organized rallies in support of Hamas, the military stepped into the political sphere for a fourth time and Erbakan was forced to resign. In 1998, the Constitutional Court banned the RP from politics altogether. In the years to come, the military would keep a watchful eye over the successive governments (Öktem 2011, 84-121).

During the 1990s, structural deficits of the Turkish economy, the inability of coalition governments to impose fiscal discipline, as well as a number of exogenous factors, led to a series of economic crises in

1991, 1994, 1998, 2000 and most prominently, in 2001. In 1999, after Turkish debt had spiraled out of control, the IMF stepped in and the government had to sign a comprehensive stability agreement and launch a major reform program as a precondition to further loans. Government spending was curbed, privatization of state-owned companies was facilitated, the banking sector became subject to regulation, and the exchange rate was pegged to lower inflation rates. However, a rising current account deficit and large deficits, especially at public banks, resulted at first in the collapse of the private banking system in November 2000 and in a devastating financial crisis a year later. After a massive outflow of capital, the Turkish government was forced to accept a drastic 50 percent devaluation of the Turkish lira, with widespread consequences for Turkish households (Çarkoğlu and Kalaycıoğlu 2007, 44-45).

In the elections of 2002, the Turkish electorate drew the consequences of a decade of failed politics and economic crises. None of the political parties re-entered parliament. Instead, the AKP, which was founded by former members of the RP and other conservative parties, polled 32.4 percent of the votes and due to the electoral system, won 66 percent of the seats in parliament.

The economic growth Turkey witnessed in the post-coup era came at a price and the social outcome of the liberalization of the economy was devastating. Once protected by state policies, the industrial labor force suffered drastic economic cutbacks and real wages dropped significantly. Already in the 1980s, many households had to resort to employment in the informal sector to keep household income stable, and the crises of the 1990s dramatically deteriorated the situation (Pamuk and Owen 1998, 117-22). Living conditions in the countryside were even more difficult. During the 1980s, the ANAP had neglected the rural economy and the crises of the 1990s affected the agricultural sector disproportionately. As a consequence of the economic situation and the ongoing war in southeast, Turkey witnessed massive urbanization during the 1980s and 1990s. Between 1980 and 2000, Istanbul's population more than doubled (Keyder and Buğra 2003, 25). While in 1980 approximately 50 percent of the labor force was working in agriculture, that number had dropped to 34 percent in 2004 (OECD 2006, 8).

The Turkish governments during this period reacted reluctantly to the new social challenges. Hardly any reforms were aimed at providing social assistance to the new urban poor and other underprivileged segments of society. At the same time, the establishment of a sustainable social security system was no priority for the decision makers in Ankara. Instead, especially during the 1990s, unsustainable pension reforms that aimed at short-term popular support from the urban middle class led to a mounting deficit in social insurance schemes. It was not before the end of the 1990s that a debate among policy makers on the future of the Turkish social security system led to a more strategic approach of social policy reform (Buğra and Keyder 2006, 213). This debate paved the way for those changes in healthcare policy which I analyze in the second part of this thesis.

The socio-economic transformation of the country and the fallout from the Kurdish conflict had deeply affected the Turkish healthcare system. The gap in regional development also manifested in significant inequalities with regard to access and quality of healthcare. Although the socialization of healthcare was formally completed in 1984, access to the MoH's outpatient care network was limited, especially in rural areas. At the same time, hospitals were predominantly located in major cities and chronically underfunded and understaffed. Urbanization further deteriorated the situation and Turkish hospitals were characterized by overcrowded outpatient departments and long waiting hours. Access to and quality of inpatient care services were equally poor. In consequence, the health status of the Turkish population varied significantly across regions. The Kurdish southeast, in particular, lagged behind with higher rates of infectious disease and infant mortality (Ağartan 2008, 237-40).

In its political rhetoric, the ANAP government stressed the necessity to extend the coverage of the social insurance system and to increase the efficiency of healthcare providers through privatization and decentralization. However, despite significant political and public interest, only few policy reforms were implemented in the 1980s and 1990s (Ibid., 263).⁷⁴

One of these reforms was the integration of healthcare to the benefits package of the *Bağ-Kur* and the extension of the scheme to agricultural workers in 1983. In consequence, according to official data, coverage of public health insurance increased from 38.4 percent in 1980 to 55.1 percent in 1990 (OECD Health Statistics 2016). However, reforms of the social insurance system under the ANAP government further consolidated existing inequalities in the social insurance system. Premium rates, as well as the benefits packages, varied significantly and access to certain healthcare institutions, such as university and hospitals owned by the SSK; was restricted to civil servants and formal sector employees. In consequence, the social insurance system created a hierarchy across the schemes that led to substantial inequalities between occupational groups (Ağartan 2008, 240).

The most important healthcare reforms of the post-coup era was the introduction of the Green Card scheme in 1992 as part of the Law Concerning State Coverage of Treatment Expenses of Citizens Who Lack the Ability to Pay by Issuing a Green Card (*Ödeme Gücü Olmayan Vatandaşları Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun*). In response to the massive influx of urban migrants working in the informal sector, the Green Card granted the poor access to inpatient care in MoH facilities as well as university hospitals following referral. Although the scheme suffered from numerous deficits, such as vague entitlement criteria and insufficient coverage and misuse, the reform has to be seen as a milestone in Turkish social history in that the state acknowledged its responsibility for the most vulnerable segments in society (Ibid., 259-61; Yoltar 2009).

⁷⁴ In 1988, parliament passed the Formation on Education, Youth, Sports, and Health Taxes Law (*Eğitim, Gençlik, Spor ve Sağlık Hizmetleri Vergisinin İhdası*) which aimed at the creation of a general health insurance and the reorganization of healthcare provision by emphasizing the role of the private sector by turning public institutions to private health enterprises. However, the reform was blocked by the Constitutional Court.

It should be highlighted, that while the state only reluctantly engaged in welfare and healthcare provision, actors such as NGOs and municipalities gained some importance during the 1980s and 1990s. However, their overall impact must be considered limited (Keyder and Buğra 2003, 33).

Furthermore, based on a new liberal conservative discourse, post-coup governments also tried to strengthen the role of private actors in healthcare provision. Private service provision was promoted through state subsidies and, perhaps more importantly, absence of state control and regulation. The number of private outpatient care facilities, such as practices, polyclinics, and medical centers, increased visibly during the 1990s and a significant share of doctors worked part-time in private facilities (Tokat 1993, 45). At the same time, private hospitals gained importance. Between 1990 and 2000, the share of private hospital beds increased from 5.2 percent to 22.1 percent (TurkStat 2009, 60; World Bank 2003a, 13). However, the privatization of healthcare provision was limited to the industrialized western parts of Turkey, which further contributed to the quality gap in healthcare across regions.

In sum, during the 1980s and 1990s, which were marked by the rise of the liberal conservative paradigm of capitalist development, the state only reluctantly engaged in welfare and healthcare provision. Only few social policies were successfully implemented. Municipalities and civil society actors gained some importance but they did not have the necessary capacity to tackle the tremendous socio-economic challenges Turkey faced during the period. Furthermore, in the post-coup era, civil society activism was still perceived as a threat to the political authority of the state.

In consequence, the existing problems of the two-tier public healthcare system prevailed and informal actors continued to play a key role in healthcare financing and provision. This led to a substantial fragmentation of the Turkish healthcare system. The state-owned preventive and curative outpatient care system was financed insufficiently and most facilities were understaffed. The war in the Kurdish southeast contributed to disparities between regions with regard to access to healthcare and the quality of services. The social insurance system excluded large segments of society and, at the same time, created a hierarchy among occupational groups. The introduction of the Green Card scheme during this period stands alone as a clear milestone in the development of the Turkish healthcare system. For the first time, a healthcare policy explicitly targeted underprivileged groups in society.

Simultaneously, market actors gained importance. Underpinned by the liberal conservative paradigm of capitalist development, the state facilitated the rise of for-profit care providers in the western metropolises through underregulation and state subsidies. However, the lack of commitment of the post-coup governments to tackle social challenges through substantial policy reform, and the inability of non-government actors to fill the gap, suggests that informal care networks, and most prominently family members, continued to carry the main burden of healthcare financing and provision.

2.6 The rise of the AKP and the reform of the Turkish healthcare system

After 12 years of weak coalition governments, political instability, and economic crises, the elections of 2002 catapulted to power a new center-right party rooted in political Islam. The new AKP government was briefly headed by Abdullah Gül, before the charismatic Recep Tayyip Erdoğan took over the reins as prime minister less than a year later.⁷⁵

While key figures of the party had previously been affiliated with Erbakan's RP, the AKP officially distanced itself from traditional Turkish political Islam, particularly the idea of replacing the secular republic with an Islamic state. Instead, under the label of conservative democracy (*muhafazakâr demokrasi*), the party propagated a synthesis of Islamic values and liberal freedoms. As Abdullah Gül put it: "We were to prove that a Muslim society is capable of changing and renovating itself, attaining contemporary standards, while preserving its values, traditions and identity" (quoted in Duran 2006, 288).

In the early 2000s, the AKP managed to build a broad coalition of economic and social groups, reaching from the Anatolian Tigers to the traditional industrial bourgeoisie, from Islamists to Kurdish groups, as well as liberals eager to finally overcome the country's authoritarian past. This coalition was strongly opposed by secular groups that alleged the AKP was harboring an Islamist agenda. Although the secular opposition, represented by the CHP, had won only a minority of seats in parliament, its followers held central veto points in the political system, most importantly the Constitutional Court, the National Security Council and the presidency. In light of the political instability of the 1990s and the strong political opposition to the AKP, most domestic and international observers predicted a swift end to the AKP's success. However, things would turn out very differently. Throughout the 2000s, the AKP was able to consolidate its power and marginalize the political influence of its opponents.⁷⁶

The AKP's reign can be roughly divided into two phases. Between 2002 and 2007, the government implemented a number of key reforms in the field of minority rights and fundamental freedoms. At the same time, it managed to strip the military of its political influence and weakened a key veto player in the political system, the National Security Council.

During this initial phase, the EU emerged as an important ally for Erdoğan's AKP. On the one hand, the official opening of membership negotiations with the European Commission in 2005 provided the government domestic and international legitimacy, as well as a certain level of security against the perpetual risk of either being banned from politics by the Constitutional Court or overthrown by the military. On the other hand, the AKP could avoid the blame for controversial political reforms by

⁷⁵ Erdoğan had served a four-month prison sentence and was banned from political activities following a conviction for the incitement to violence and religious or racial hatred after he cited a poem by Ziya Gökalp. After legal changes, Gül handed over his post to Erdoğan.

⁷⁶ For an historical overview see: Öktem 2011, 157-84; Kumbaracıbaşı 2009.

framing legal changes as part of the adaption process of the EU's *acquis communautaire* and Copenhagen Criteria (Saatcioğlu 2014; Duran 2008).

The second phase of AKP rule began in 2007 when Erdoğan was re-elected in parliamentary elections with 47 percent of the vote. That same year, Abdullah Gül became president, granting the AKP a second key veto position in the political system, even though the party had lost some seats in parliament.

In the following years, democratic reforms slowed down visibly and after Erdoğan was re-elected in 2011, the government began to resort to more overt authoritarian measures. At first, hundreds of military personnel were indicted in dubious mass trials, while thousands of members of leftist and Kurdish groups, including politicians and journalists, were separately rounded up on terrorism charges. Since the Gezi protests of 2013 and the split with the Fethullah Gülen religious movement, the government has responded to political opposition with a broad crackdown on political parties, civil society organizations, as well as businesses and media outlets owned by members of the opposition. Freedom of expression and the press has greatly deteriorated (Corke et al. 2014). In the summer of 2015, political conflict and societal polarization were at boiling point. The conflict with the terrorist PKK and affiliated groups escalated. Major cities in the Turkish southeast turned into war zones, leaving over 200 civilians dead and displacing over 100,000 (Blaser and Stein 2016). Turkey had, once again, entered a dark era marked by authoritarianism, societal polarization, and ethnic conflict.

In August 2014, Erdoğan was elected president by popular vote for the first time in Turkish history. One of the key messages of his campaign was the need to transform Turkey's parliamentary system into a presidential one. However, in the general elections of June 2015, the share of votes for the AKP, which was now led by Prime Minister Ahmet Davutoğlu, dropped significantly to 40.9 percent. For the first time in 13 years, the AKP had lost its overall majority and Erdoğan's project of a presidential system appeared to have become derailed. However, after the political parties in parliament were unable to form a coalition government, snap elections were held in November 2015. In another landslide victory the AKP gained 49.5 percent of the votes, putting the transformation of the Turkish political system back on the agenda (Çarkoğlu 2015).

In May 2016, Davutoğlu resigned in a surprise move and Binali Yıldırım became the new prime minister. Most observers explain this move due to increasing political tension between Davutoğlu and Erdoğan. They claim that the nomination of Yıldırım as prime minister will further concentrate political power in Erdoğan's hands and speed up the transformation to a presidential system (Akyol 2016).

Accordingly, it can be argued that the AKP, and in particular Erdoğan, succeeded in consolidating political and economic power. The filling of a key veto position in the political system with party affiliates and a series of legal changes, strengthened the government's influence on key institutions in the military and the judiciary, as well as the police and higher education. Posts in public institutions, so

it seemed, were exclusively filled with devoted party affiliates who slowly undermined the influence of secular groups in the bureaucracy.

However, the narrative of the AKP's unchallenged political hegemony collapsed on the night of 15 July 2016 when elements within the military attempted to overthrow the government. The coup was foiled, thanks to a loyal and strengthened national police force but, most significantly, by thousands of civilians who poured out onto the streets in defiance of the putschists, some 150 of them who were killed in the process. Most observers agree that the religious cult around Fethullah Gülen was involved or even the main actor behind the clandestine network which organized the attempted coup. The AKP government reacted quickly and detained thousands of soldiers and dismissed tens-of-thousands of public employees (Gürsel 2016). While public support for Erdoğan and the AKP government has probably never been stronger, the long-term impact of the attempted coup on Turkish politics remains to be seen. Many fear an indiscriminate crackdown on the political opposition and further polarization. Furthermore, the question remains how the mass expulsion of civil servants will restrain the AKP's capacity to govern the country.

The AKP's unwavering public support over the last 14 years has puzzled many observers. The party's success can be partially explained through the inability of the opposition to offer political alternatives and the growing polarization of society along ethnic lines (Keyman 2015). However, it is the remarkable growth of the Turkish economy since the AKP came to power that has earned it such widespread support. Since 2002, nominal GDP has more than tripled, inflation has been stabilized and public debt reduced to a minimum (Subaşat 2014). In consequence, living conditions, especially in the poorer segments of Turkish society, have drastically improved. Between 2002 and 2011, extreme poverty fell from 13 to 5 percent and moderate poverty from 44 to 22 percent. A boost in shared prosperity has given a lift to the bottom 40 percent of the population and has contributed to a growing middle class (Azevedo and Atamanov 2014, 6-8).

In this context, a number of studies highlight the neo-liberal underpinnings of the AKP's economic reforms (Tuğal 2009; 2016; Eder 2013). Buğra and Savaşkan argue that these must be understood as a continuation of the reforms of the 1980s and 1990s in which government and non-government actors formed a coalition that was ideologically framed by the new paradigm of liberal conservative capitalism. They argue that in line with the political economy of the 1990s, the AKP reforms did not put an end to state intervention in the economy and were marked by clientelism and patronage (2014). Corruption allegations in 2013 leveled against the government and Erdoğan's immediate family highlight further the close relationship between the government and business in Turkey (Ulusoy 2014). While the government has to date successfully prevented any independent investigation into the allegations, the scandal raises the question of how far liberalization of the Turkish economy, in the form of privatization and de-regulation, has led to an informalization of state-business relations.

However, further research is needed to investigate how far corruption, clientelism, and patronage contribute to the popular support of the AKP.

In addition to its economic success, the government and AKP-run municipalities have implemented numerous reforms which have been aimed at the social inclusion of underprivileged groups, contributing to their popularity. Many of these reforms were framed by religious rhetoric and contributed to the visibility of Sunni Islam in public (Göçmen Yeginoğlu 2010, 115-25). In retrospect, the AKP has significantly improved access to public services, such as housing and transportation, and has realized major infrastructure projects that have increased the living standards of many Turks (Prime Ministry 2013).

One of the key reforms of the AKP was the HTP, which comprised a multitude of policy reforms, many of which have been achieved since its launch in 2003: a mandatory health insurance system that provides universal access to care has been established; the fragmented social insurance system has been centralized, a purchaser and provider split has been introduced; the ownership of most hospitals has been transferred to the MoH; the tax-funded preventive and curative care system was restructured to a family physician system, introducing a performance-based payment system for doctors.

While more research is necessary to verify causality, it can be assumed that the reforms of the HTP have led to significant improvements in the health status of the population. Between 2002 and 2012, life expectancy increased from 71.9 to 74.6 and the infant mortality rate has dropped from 29.6 to 11.6 per 1,000 live births (OECD Health Statistics 2016). While only about two-thirds of children were vaccinated against Diphtheria, Tetanus, Pertussis and Hepatitis B in 2002, Turkey had reached almost full immunization levels against these diseases by 2012 (OECD 2014, 136).

However, a number of scholars have criticized the reforms of the HTP, arguing that they are part of a larger neo-liberal transformation of Turkish society (Eder 2013; Yılmaz 2013). While these studies focus on the new role of the market vis-à-vis the state, there has yet been no comprehensive analysis of changes in healthcare policy and the transformation of the constellation of actors who are engaged in healthcare financing, provision, and regulation. Accordingly, by examining the transformation of the Turkish healthcare system I make a contribution to a relatively unexplored field of social science and Turkish Studies.

2.7 Interim results

This chapter has shown that with regard to the emergence of modern healthcare institutions, the Turkish experience deviates from Western and Northern European welfare states. The state's engagement in the provision of welfare and healthcare was neither triggered by class struggles, as proposed by power

resource approaches, nor has it been a response to social and economic changes, as suggested by structuralist approaches. Instead, the historical institutional analysis has shown that the establishment of healthcare institutions was a deliberate policy choice by state actors with the goal to utilize welfare programs for authoritarian nation-building and capitalist development.⁷⁷ This premise was encoded in the structure of institutions that provided and financed healthcare since the late Ottoman Empire. Accordingly, the first key finding of this chapter is that the design of modern healthcare institutions in Turkey was based on the leitmotif of hierarchical state control.

The second finding is that the modernization of healthcare institutions during the history of the Turkish Republic has been characterized by a high level of path dependency. During the first half of the 20th century, healthcare financing and provision was strictly controlled by state institutions. A fragmented welfare system emerged which protected occupational groups according to their relationship toward the state apparatus. The state was the predominant actor that hierarchically controlled the role of civil society in healthcare financing and provision. The role of the market was marginal and limited to the provision of services to wealthier citizens in urban Turkey.

The third key finding is that in light of the absence of societal and structural pressures, the state only reluctantly engaged in the realm of healthcare. Given that the majority of the population had only limited access to often rudimentary services, it can be assumed that the family played a significant role in the financing and provision of healthcare.

Since the 1990s, a combination of structural pressures and the rise of the liberal conservative paradigm paved the way for changes in the Turkish healthcare system. The state extended the coverage of the health insurance system and gave the poor free access to rudimentary inpatient curative care. At the same time, unregulated by the state, for-profit providers gained momentum in urban Turkey and, in return, the importance of households in healthcare financing increased.

Despite these changes, I argue that the reforms of the 1990s did not constitute a paradigm change in healthcare policy. Already prior to the rise of the liberal conservative paradigm, the state had only loosely regulated for-profit actors. State authorities not only turned a blind eye to informal out-of-pocket payments, they furthermore created favorable conditions for government-employed doctors to supplement their low salaries through household out-of-pocket payments.

Accordingly, when the AKP came to power, the healthcare system was marked by deep fragmentation and high levels of inequity and inequality. Numerous different systems of healthcare financing and provision co-existed and approximately one-third of the population was not covered by health insurance. The state exerted a high level of hierarchical control over governmental and non-governmental institutions which provided only rudimentary services to the public. The role of market actors had increased but was still

⁷⁷ Here, Turkey shows similarities to other late industrializing countries which could lay the ground for comparative research (compare Gough and Wood 2004).

limited to the provision of services to wealthier citizens living in western cities. In sum, the healthcare system had only little in common with its counterparts in mature welfare states and a sound empirical footing was missing, which would suggest that an analysis of the Turkish case could contribute to a better understanding of contemporary healthcare systems beyond the late-industrializing world.

I argue that with the comprehensive healthcare reforms of the HTP this picture has changed. The political hegemony of the AKP has created a critical juncture which opened a window of opportunity for a paradigm shift in healthcare policy. Accordingly, I argue that the reforms of the AKP may stand at the beginning of a new institutional legacy that will most likely shape the Turkish healthcare system for the coming decades.

In the next chapter, I highlight the scope and characteristics of this transformation through the classification of the Turkish case in the most prominent typology of healthcare systems. I show that under the AKP government, Turkey has in many regards caught up with the healthcare systems of mature European welfare states. However, I also show that key individual characteristics of the Turkish healthcare system persist such as the strong role of the family in healthcare financing and the strict regulation of the healthcare providers by the state persist.

3. Classification of the Turkish healthcare system

In 1987, the OECD published a report prepared by George J. Schieber entitled “Financing and Delivering Healthcare. A Comparative Analysis of OECD Countries”. Using a comprehensive set of indicators, the study’s main goal was to compare healthcare expenditure, price, and utilization trends in OECD countries (OECD 1987, 11). In retrospect, however, its most important contribution to the field has been its comprehensive description of the three ideal types of healthcare systems that have dominated the academic literature to date, namely the National Health Service Model, the Bismarck Model, and the Private Insurance Model (Burau and Blank 2006, 64-65). In the following, I attempt to classify the Turkish case according to this typology.

As Max Weber highlights, “[i]deal types are the safe harbors to help one navigate the enormous ocean of empirical facts” (Weber 1995, 9).⁷⁸ They are heuristic devices that through simplification, allow us to skirt the complexities of the real world. At the same time, they enable us to move beyond the specifics of the Turkish case toward a more generalized perspective, without getting caught up in the methodological intricacies of comparative policy analysis (Arts and Gellisen 2002, 138-40). Accordingly, the relative stability of the ideal types Schieber describes, allows us to identify changes in the Turkish healthcare system.

This chapter illustrates that since the AKP came to power, the Turkish healthcare system has undergone a substantial transformation, with an analysis of the key indicators showing that it has narrowed the gap with healthcare systems in mature welfare states. However, juxtaposition of ideal types with data from real types that feature health insurance systems reveals that the Turkish case is consistently marked by distinctive traits, most noticeably the strong role of the family in healthcare financing and the high level of state regulation of healthcare providers. The persistence of these traits suggests that Turkey embarked upon a path of modernization different from Western and Northern European experiences. Accordingly, this chapter lays the ground for the second part of this thesis, which provides an in-depth analysis of changes in healthcare policy and the institutional transformation of the Turkish healthcare system.

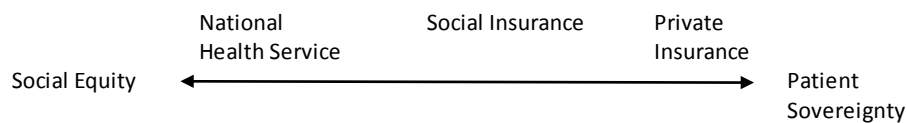
With only few comparative studies in healthcare analysis that include Turkey to date, this chapter serves as an important insight into the workings of the Turkish healthcare system. The following classification in the OECD typology has to be put in context with the findings on the historical development of healthcare institutions, and their embedment into the wider political and socio-economic environment (compare Burau and Blank 2006, 65). Therefore, in addition to a review of the theoretical and institutional aspects of the Turkish healthcare system, an identification of fits and

⁷⁸ The German original text is “Idealtypen sind gleichsam “Nothäfen”, um sich auf dem ungeheuren Meer der empirischen Tatsachen zu orientieren“.

misfits between the Turkish real types and the existing ideal types, enable me to formulate informed hypotheses, which then facilitate deeper analysis of the institutional transformation of the Turkish healthcare system.

Schieber argues that in order to investigate thoroughly the performance of different health systems, the implicit and explicit incentives they inherit have to be analyzed according to five dimensions: (i) financing procedures; (ii) eligibility criteria; (iii) benefit provision; (iv) reimbursement procedures; and (v) organization and development of the delivery system. However, due to the diversity of real types, as well as the lack of data, his typology of healthcare systems is not based on indicators from all five dimensions. Instead, his ideal types are established along a dichotomy of patient sovereignty and social equity (OECD 1987, 24).

Figure 1: Types of healthcare systems by provision and funding



Source: Burau and Blank 2006, 65.

Schieber's typology consists of three models of health systems: First, the National Health Service Model, or Beveridge Model, assures a high level of social equity through universal health coverage, a predominant financing of healthcare through tax revenue, as well as national ownership and control over healthcare facilities. Second, in the Social Insurance Model, or Bismarck Model, we find a medium level of social equity and patient sovereignty. Universal coverage is provided through mandatory health insurance schemes. Accordingly, healthcare is financed by employer and employee premiums that are pooled by non-profit insurance funds. Facilities of healthcare provision are both publicly and privately owned. Third, in the Private Insurance Model, or Consumer Sovereignty Model, the level of patient sovereignty is highest. Employers or individuals purchase private health insurance while healthcare facilities are privately organized. Schieber stresses that none of these ideal types can be found in the real world and that all existing healthcare systems contain elements of more than one model. Nevertheless, the models of his typology derive from prototypical real types, in particular, the UK and Italy for the National Health Service Model, Germany and France for the Social Insurance Model, and the USA for the Private Insurance Model (Ibid., 24).

Schieber argues, that in principle, all healthcare systems are driven by the same motive: to provide access to "quality care for all citizens while achieving efficiency in the use and provision of services" (Ibid., 24). However, in order to achieve this goal, healthcare systems vary significantly regarding the

incentives they give through their financial and organizational structure. Critics of Schieber's typology argue that the notion of a universal quest for efficiency and equity among health systems ignores the impact of their social, economic and political environment. Accordingly, Richard Freeman argues that Schieber's typology has been driven predominantly by the premise to develop policy solutions for cross-national challenges in healthcare (Freeman 2000). However, despite neglecting the power structures that underpin health systems, Schieber's typology has had a tremendous impact on the field, serving as a starting point for numerous comparative studies (Blank and Burau 2007, 12).⁷⁹

In the following, I employ the key indicators used in Schieber's study to classify Turkey within the three models, using data from the prototypical types as a reference. In order to trace changes in the Turkish healthcare system, I examine mostly quantitative data from 1990, 2003, and 2013 (or nearest year available). Data from 1990 has been included in order to trace the trajectory of the transformation of the Turkish healthcare system, and to highlight changes that would indicate a paradigm shift in healthcare policy since the AKP came to power.

3.1 Financing procedures

Schieber highlights that financing procedures of healthcare systems, to a large extent, determine their redistributive impact and the allocations of resources, as well as economic growth in general. He argues that healthcare systems can be financed through general taxes (such as income tax or value added tax), specific taxes (such as excise taxes), premiums, user charges (such as copayments), charitable contributions, and foreign assistance (OECD 1987, 25).

As specific data relating to the breakdown of the sources of government expenditure is not available for Turkey, general and specific taxes are condensed to the indicator used by the SHA 2011, namely the health expenditures of "government schemes". Accordingly, premiums are divided into "compulsory contributory health insurance schemes" and "voluntary healthcare payment schemes". User charges are included in the comparison as "household out-of-pocket payments". Two of the financing sources for healthcare listed by Schieber are not included in the comparison offered below: "charitable contributions" and "foreign assistance" play a marginal role in the healthcare systems of the countries under discussion.

⁷⁹ For studies using Schieber's typology as a starting point see: Wall 1996; Ham 1997; Freeman 2000.

Table 1

Current expenditure on healthcare by financing scheme as percentage of total expenditure, early 1990s

	Government schemes	Compulsory contributory health insurance schemes	Voluntary healthcare payment schemes	Household out-of-pocket payments
France	5.9	66.4	9.4	17.4
Germany	12.0	66.2	7.7	12.9
Italy	35.2	40.3	4.8	19.6
Turkey	44,1 (a)	16.8 (a)	0,1 (b)**	29.1 (a)
UK	72.7	7.6	2.9	18.6
USA	24.8	18.6	31.3	3.2

Source: Cichon et al. 1999, 41; (a) Tokat 1993; (b) Tokat 1998.

Table 2

Current expenditure on healthcare by financing scheme as percentage of total expenditure, year 2003

	Government schemes	Compulsory contributory health insurance schemes	Voluntary healthcare payment schemes	Household out-of-pocket payments
France	3.5	75.3	13.8	7.4
Germany	7.6	70.9	8.6	12.8
Italy	75.3	0.1	0.9	23.7
Turkey	27.0	44.2	3.7* (a)	18.9
UK	79.3**	--	9.0	11.7
USA	44.9**	--	40.9	14.2

Notes: *2000 **general government spending incl. social security

Source: OECD Health Statistics 2016; (a) Tatar et al. 2011.

Table 3

Current expenditure on healthcare by financing scheme as percentage of total expenditure, year 2014

	Government schemes	Compulsory contributory health insurance schemes	Private insurance	Household out-of-pocket payments
France	4.1	74.5	14.4	7.0
Germany	6.6	78.0	2.4	13.0
Italy	75.5	0.3	2.2	22.0
Turkey	21.3	56.3	4.7	17.7
UK	79.5	0.1	5.7	14.8
USA	26.1	23.1	39.2	11.5

Source: OECD Health Statistics 2016.

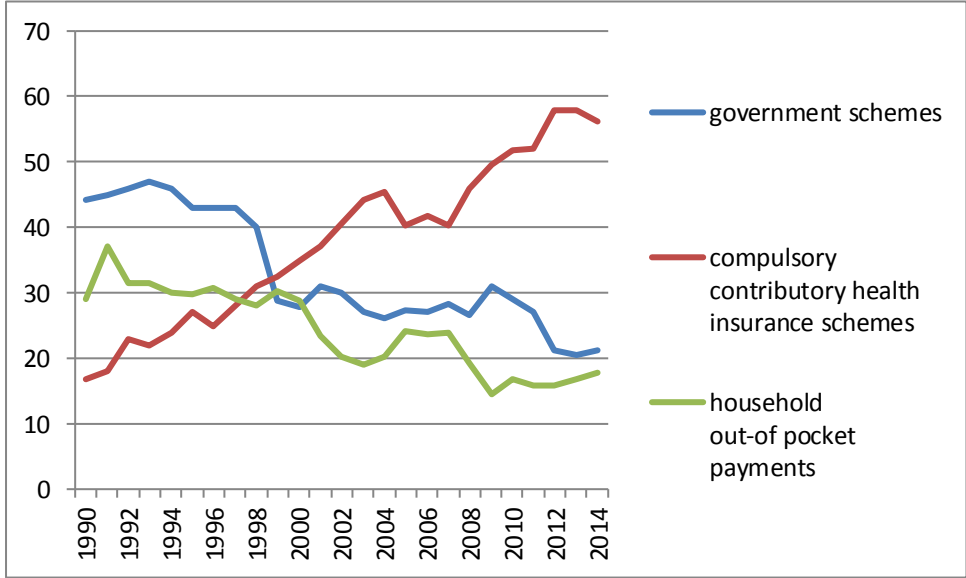
A closer look at financing data from 1990, 2003 and 2013 shows that the prototypical real types identified by Schieber can be easily assigned to the three ideal types. Furthermore, over the past few decades, there have only been marginal changes to the key financing agents in the respective health systems. France and Germany remain financed predominantly through social security contributions, while the health systems in Italy and the UK are consistently financed through tax revenues. In the US,

the prototype of the Private Insurance Model, social insurance funds have gained importance in healthcare financing over the last two decades, and have become a key financing agent. However, the importance of private insurance funds for healthcare financing remains unchallenged.

In contrast, the Turkish case neither resembles any of the three ideal types, nor does it show similarities to the real types examined by Schieber. Instead, financing of the Turkish health system is characterized by a unique mixture of public resources as well as comparatively high out-of-pocket payments. Voluntary health insurance schemes have gained importance in recent decades, although they still cover a very limited segment of society: in 2014, 4.7 percent of the Turkish population was covered by private insurance schemes (OECD Health Statistics 2016).

The cross-temporal comparison of data from Turkey shows significant shifts between financing schemes over the past few decades. In order to better trace this development, Graph 2 shows the changes in healthcare financing based on annual data.

Figure 2
Current expenditure on healthcare by financing scheme as percentage of total expenditure in Turkey, years 1990 to 2014



Source: OECD Health Statistics 2016; MoH 2001a; MoH 2001b; Tokat 1993; Tokat 1998; TurkStat 2009.

Between 1990 and 2013, the share of total health expenditure financed by social insurance schemes increased steadily, while the government’s role as financing agent declined. Particularly striking is the significant decrease in out-of-pocket payments by more than 12 percentage points. Official data for out-of-pocket payments is available from the year 1992 onwards. Earlier data in the graph above refers to private healthcare expenditure in total. It needs to be highlighted that in the late 1980s, the share of out-of-pocket payments was well above 40 percent, which made households the biggest

financing agents of healthcare at the time (Tokat 1993, 42). With this massive reduction in out-of-pocket payments, Turkey also stands out when compared to other OECD countries. Between 2000 and 2011, the share of out-of-pocket expenditure as a share of total expenditure on health in Turkey was reduced by 10.3 percentage points, while the OECD average lay at 1.2 percent (OECD 2013, 165).

However, cross-national comparison shows that despite their reduction, out-of-pocket payments remain high in Turkey. High out-of-pocket payments commonly correlate with high catastrophic health expenditures and have a negative impact on the equity of health systems (Xu et al. 2003). Accordingly, I analyze in detail below, the importance of households as financing agents in the Turkish healthcare system.

In sum, changes in healthcare financing over the past few decades suggest a substantial transformation of the Turkish healthcare system. However, the analyzed data suggests that this transformation had already begun prior to AKP rule and the implementation of the HTP reforms.

Turkey does not match the characteristics of the ideal typical Social Insurance Model, or Bismarck Model, and differs from real types, such as Germany. The key financing agents in contemporary Turkey are social insurance funds. At the same time, the government remains a key financing agent, covering around one-fifth of total health expenditure. The distinct mixture of public financing sources, as well as the outstanding importance of out-of-pocket payments, set the Turkish case apart from the three ideal types described by Schieber. The limited role of private insurance schemes suggests a low level of patient sovereignty in healthcare financing. At the same time, the data displayed in this section shows that a significant percentage of Turks depend on their household's capacity and willingness to finance medical services. Accordingly, high levels of out-of-pocket payments indicate significant social risks related to illness and a generally low level of social equity in the Turkish healthcare system.

3.2 Eligibility criteria

Schieber states that in most OECD members' health systems the predominant schemes cover the vast majority of citizens. However, differences remain with regard to basis of entitlement in different health systems, as well as inequalities in eligibility of healthcare through the exclusion of underprivileged groups in society.

Table 4

Coverage of healthcare systems as a percentage of the population

	Total public and primary private health insurance, year 1990	Total public and primary private health insurance, year 2003	Total public and primary private health insurance, year 2014
France	99.4	99.9	99.9
Germany	88.8	99.7	99.8
Italy	100	100	100*
Turkey	55.1	71.6	98.4
UK	100	100	100
USA	84.5**	85.4	85.5

Notes: *1997 **2013

Source: OECD Health Statistics 2016.

Table 5

Predominant mode of healthcare entitlement

	Predominant mode of healthcare entitlement, year 1990	Predominant mode of healthcare entitlement, years 2008 and 2009
France	Statutory coverage	Compulsory coverage
Germany	Statutory coverage	Compulsory coverage
Italy	Automatic coverage	Automatic coverage
Turkey	Statutory coverage	Compulsory coverage
UK	Automatic coverage	Automatic coverage
USA	Voluntary coverage	Voluntary coverage

Source: Abel-Smith and Mossialos 1994; Busse and Riesberg 2004; U.S. Congress 1995; Hurst 1991; Paris et al. 2010; OECD Health Statistics 2016.

Almost two and a half decades after the OECD published Schieber's study, all prototypical cases have managed to expand coverage of their health systems to an almost universal level, except the USA, where voluntary coverage remains the predominant mode of entitlement, and where approximately 14.5 percent of the population have no access to healthcare.

Inequities in access to healthcare persist to a certain level in all countries included in Schieber's study, however, the findings from Turkey stand out. Prior to the reforms of the HTP, a significant percentage of the Turkish population was not covered by any of the existing social insurance schemes. The analyzed data suggests that over the last decade, the Turkish government has managed to extend coverage of the healthcare system to almost the entire population. In Chapter 5, I discuss to what degree official data can be considered accurate. However, there is no doubt that the reforms of the AKP have significantly increased the coverage of the Turkish healthcare system.

Accordingly, in terms of eligibility criteria, Turkey neither matches the characteristics of the ideal types discussed in Schieber's study, nor does it resemble any of the real types prior to the HTP reforms. As Turkey had predominantly ensured coverage of its population through statutory coverage, it follows that the country used to be a representative of the Social Insurance Model. However, until recently, it

failed to offer the level of coverage found in the prototypical cases of France and Germany. With the introduction of compulsory healthcare, not only in Turkey, but also in France and Germany, this picture has changed. Hence, with regard to eligibility criteria, Turkey now resembles the real types of the Social Insurance Model.

In sum, under AKP governance Turkey has shown a remarkable performance by integrating large segments of society into the healthcare system. Similar to the shift between financing agents, this transformation suggests the successful implementation of government healthcare policies over the past few decades. However, more in-depth analysis of policy changes with regard to access criteria is necessary to verify this claim. In the second part of this thesis, I show that a number of AKP policies have been aimed at extending coverage of the healthcare system.

Given the insignificance of private health insurance, the low coverage of the Turkish healthcare system indicates a tremendous importance of households in healthcare financing prior to the AKP reforms. Accordingly, it can be assumed, that compared to previous decades, the family has lost its predominant role in the Turkish healthcare system.

3.3 Benefit provision

Schieber argues that health systems, to a large degree, differ regarding the benefits that are covered by the predominant schemes. While curative care and diagnostic services are generally covered by all primary schemes investigated in his study, a high level of diversity among OECD health systems can be observed when focusing on the coverage of medical goods and services such as medication, eyeglasses, nursing homes, and home care. Equally, cost sharing for outpatient and inpatient care, understood as a form of benefit reduction, contradicts the welfare aims of the countries in the National Health Service group, as well as Germany, but is tolerated in France and the USA. In contrast, cost sharing for pharmaceuticals is common in most OECD countries. All OECD countries also provide individual and collective benefits, such as preventive care, health education, and technical development (OECD 1987; for recent data see Paris et al. 2010).

Manifold differences across countries, as well as variations in benefits packages within individual healthcare systems, make it difficult to derive characteristics of ideal types from prototypical cases. Accordingly, while Schieber identifies indicators to compare benefit provision among healthcare systems, he neglects this dimension in the construction of the three ideal types. At this point, due to the lack of available data, the countries under discussion are only compared along two indicators which focus on cost sharing: “typical range of costs for primary care physician contact covered by basic primary health coverage” and “typical range of pharmaceutical costs covered by basic primary health coverage”.

Table 6
Cost sharing for outpatient care

	Typical range of costs for primary care physician contact covered by basic primary health coverage, early 1990s	Typical range of costs for primary care physician contact covered by basic primary health coverage, year 2005	Typical range of costs for primary care physician contact covered by basic primary health coverage, years 2008 and 2009
France	70% (a)	51-75% (e)	70%(f)
Germany	100% (b)	76-99% (e)	100% (f)
Italy	100%* (c)	100% (e)	100%(f)
Turkey	100% (d)	100%(d)	100%(g)
UK	100%* (c)	100% (e)	100%(f)
USA	--	--	0%(f)

Notes: *1994

Source: (a) Abel-Smith and Mossialos 1994; (b) Busse and Riesberg 2004; (c) U.S. Congress 1995; (d) Socialization of Health Services Law; (e) DICE; (f) Paris et al. 2010; (g) Family Medicine Law.

Table 7
Cost sharing for pharmaceuticals

	Typical range of pharmaceutical costs covered by basic primary health coverage, early 1990s	Typical range of pharmaceutical costs covered by basic primary health coverage, years 2008 and 2009
France	40-70% (a)	51-75% (c)
Germany	100% (a)	76-99% (c)
Italy	60% (a)	100% (c)
Turkey	80% (b)	80%(d)
UK	Flat rate (a)	100% (c)
USA	0%	0%

Source: (a) Abel-Smith and Mossialos 1994; (b) Social Insurance Law; (c) Paris et al. 2010; (d) Social Security and General Health Insurance Law.

When comparing copayments for services provided by general primary care physicians across OECD countries in 1990, no clusters of real types emerges. Only France imposed cost sharing on patients. In the USA, where the predominant mode of entitlement to healthcare is voluntary coverage, copayments technically amounted to 100 percent. In Germany, the UK, Italy, and Turkey the basic primary schemes fully covered primary care. In 2008/09, only Turkey and the countries of the National Health Service Model, namely the UK, and Italy, offered free primary care to all citizens. Germany is not among these as it also introduced cost sharing mechanisms for some primary care services, however, fees were subsequently waived in late 2012 (Busse and Blümel 2014). It is important to note here that the findings of the historical analysis need to be taken into account. As discussed in the previous chapter, access to and quality of services provided by tax-funded preventive and outpatient

curative care facilities were limited. In consequence, they were mainly used by poorer segments of society in urban Turkey and the rural population.

The most recent comparative data for cost sharing for pharmaceuticals is from the years 2008 and 2009. For the past few decades, existing healthcare schemes in Turkey were cofinanced through out-of-pocket payments for pharmaceuticals, amounting to 20 percent of the total cost for active insurants, and 10 percent for retired insurants. In contrast, in the real types that resemble the National Health Service model, Italy and the UK, the basic primary scheme fully covered the costs of pharmaceuticals.

The differences among real types of health systems, as well as diversity in regulations, makes it difficult to allocate distinct types of benefit provision to the three ideal types under discussion. In countries belonging to the National Health Service Model, cost sharing for primary care and pharmaceuticals is uncommon. In contrast, countries grouped under the Private Insurance Model, such as the USA, impose high copayments. Turkey traditionally provides free access to primary care, however, high levels of out-of-pocket payments indicate that many citizens have to pay informal copayments or resort to for-profit providers. Accordingly, an in-depth analysis of the role of households in healthcare financing and the structure of out-of-pocket payments is necessary, which I provide in the second part of this thesis.

Pharmaceuticals have been cofinanced by households in Turkey and despite the drastic decrease in out-of-pocket payments over the past few decades the rate of mandatory copayments has remained unchanged.

In sum, Turkey resembles the countries of the National Health Service Model by providing free access to primary care. This observation appears remarkable as Turkey stands apart from the UK and Italy with regard to financing and eligibility criteria. However, more research on the structure of out-of-pocket payments is necessary to verify this claim. When focusing on copayments for pharmaceuticals, Turkey resembles the real types of the Social Insurance Model.

It needs to be stressed that benefit provision comprises a variety of policies and programs. This study only includes two indicators which both focus on cost sharing. A more comprehensive cross-national comparison of service provision should focus, in particular, on differences in benefits packages, however, this goes beyond the scope of this study. When focusing on the Turkish case, the data displayed above does not indicate significant changes. However, in the second part of this thesis I further analyze changes in the benefits packages and levels of cost sharing within the various schemes of the Turkish healthcare system.

3.4 Reimbursement procedures

Analog to benefit provision, reimbursement procedures differ significantly across OECD health systems. Additionally, they have been the object of policy reform in numerous OECD countries over the past few decades. This makes it even more difficult to derive ideal typical traits from the characteristics of real types.

Schieber argues that ownership criteria and payment methods have a tremendous impact on access to healthcare as well as on cost and quality. He argues that they inherit different incentives for the demand and supply side of medical services. In particular, ownership criteria are characteristic of different modes of state regulation of healthcare provision. In the National Health Service Model, healthcare facilities are predominantly state-owned, which indicates high levels of command and control of the state over patients and providers. In the Private Insurance Model, patients can commonly choose among a variety of services provided mostly by profit-oriented actors. High levels of patient sovereignty demand a different style of governance. Accordingly, in order to increase social equity, policy makers often regulate the behavior of patients and providers through incentives. The Social Insurance Model lies between the other models, keeping the balance between social equity and patient sovereignty.

Table 8
Ownership of hospitals

	Percentage of privately owned hospital beds of total, year 1990	Percentage of privately owned hospital beds of total, year 2003	Percentage of privately owned hospital beds of total, year 2013
France	35.1*	34.2	37.8
Germany	37.2 (a)	55.6	59.3
Italy	17**(b)	30	31.5***
Turkey	5.2 (c)	8.1 (d)	18.8 (e)
UK	--	0	0
USA	67.6	74.2	76.4***

Notes: *1997 **1993 ***2012

Source: OECD Health Statistics 2016; (a) European Observatory on Health Care Systems 2000; (b) Donatino et al. 2001; (c) Turkish Statistical Institute 2009; (d) World Bank 2003b; (e) MoH 2014.

When focusing on ownership criteria, the indicator “percentage of privately owned hospital beds of total bed stock” reveals that Germany and the USA match the characteristics of their respective ideal types. As regard the UK, it needs to be highlighted that OECD data, which is only available from the year 2000 onwards, can be considered inaccurate (OECD Health Statistics 2016). While according to official data, all hospital beds in the UK are state-owned; not-for-profit hospitals owned by non-governmental actors have traditionally been part of the British healthcare system. Additionally, since

the 1990s, a number of private for-profit hospitals have begun offering services to the public (Grimmeisen und Frisina 2010, 91). In contrast, Italy, the second prototypical case of the model, mismatched the traits of the ideal type. In 1990, the share of private beds already amounted to 17 percent and increased even further to 31.5 percent in 2013, which clearly sets the country apart from the National Health Service Model.

As regard to Turkey, the share of private beds has increased significantly between 2003 and 2013 under AKP rule. However, in cross-national comparison, the percentage of private hospital beds in Turkey is still relatively low and suggests a resemblance between Turkey and the National Health Service Model. Accordingly, following Schieber's argumentation, it can be assumed that state institutions in Turkey exert a high level of control over the hospital sector.

Focusing on hospital payment modes, the most recent comparative data available is from 2008 and 2009. Schieber stresses that the real types of the National Health Service Model, such as Italy and the UK, but also France, have implemented global or line-item budget approaches. These have the advantage of simplicity and a high level of expenditure control. In Germany, hospitals are reimbursed on a per diem basis, having the advantage of simplicity and fewer disincentives than global budgets. However, per-diem payments do not provide incentives for limiting overall expenditure. In the USA, per-case payments provide strong incentives for reduced length of stay, as well as increased admission, and a possible reduction of service quality (OECD 1987, 26-27).

Table 9

Predominant mode of healthcare remuneration

	Predominant payment mode for outpatient care physicians, early 1990s	Predominant payment mode for outpatient care physicians, years 2008 and 2009	Predominant payment mode for inpatient specialist treatment, early 1990s	Predominant payment mode for inpatient specialist treatment, years 2008 and 2009	Hospital payment scheme, early 1990s	Hospital payment scheme, years 2008 and 2009
France	Fee-for-service* (a)	Fee-for-service (c)	Fee-for-service (a)	Salary (c)	--	Per case and DRG (c)
Germany	Fee-for-service* (a)	Fee-for-service (c)	Salary (d)	Salary (c)	Per diem (d)	Per case and DRG (c)
Italy	Capitation* (a)	Capitation (c)	Salary (a)	Salary (c)	Global budget (e)	Per case and DRG (c)
Turkey	Salary (f)	Salary (c)	Salary (f)	Salary (c)	Line-item budget (f)	Line-item budget (c)
UK	Capitation* (a)	Salary + fee-for-service + capitation (c)	Salary	Salary (c)	Global budget (a)	Per case and DRG+global budget (c)
USA	Fee-for-service (b)	Salary + fee-for-service + capitation	Fee-for-service (b)	Fee-for-service	Per case and DRG (b)	Per case and DRG

Source: (a) Abel-Smith and Mossialos 1994; (b) U.S. Congress. 1995; (c) Paris et al. 2010; (d) Busse and Riesberg 2004; (e) Donatino et al. 2001; (f) World Bank 2003b.

Comparing modes of health remuneration between the early 1990s and 2008/09, it appears striking that all prototypical cases have shifted their modes of hospital payment toward “per case payments”, namely Diagnosis-related group (DRG) systems of reimbursement. This trend has provoked criticism from a number of scholars, who point to the risks of DRG reimbursement systems, namely an outbalancing of the premise of efficiency, and the reduction of costs in the hospital sector against social equity in healthcare (Buhr and Klinke 2006, 7). The common shift towards reimbursement schemes is remarkable as it suggests a convergent transformation of the healthcare systems under discussion.

In Turkey, the hospital sector to date has been financed through line-item budgets, allowing a high level of government control over healthcare expenditure. However, in congruence to the developments in Europe, a number of attempts have been made to introduce DRG payment modes in the Turkish hospital sector over the last decade (OECD and World Bank 2008, 50).

With regard to payment of outpatient and inpatient care, the prototypical countries of the National Health Service Model are generally characterized by capitation payment for outpatient care, and salaried doctors in inpatient care. In the Private Insurance Model, doctors in primary and secondary care work predominantly on a fee-for-service basis. In countries belonging to the Social Insurance Model, such as France and Germany, outpatient care is provided on a fee-for-service basis and salaried payments in inpatient care.

Turkey is characterized by a mixture of reimbursement modes. Turkish hospitals are predominantly staffed with salaried doctors, with primary care being provided in state owned facilities as well as in private settings on a fee-for-service basis. It needs to be highlighted that, until the recent reforms, a significant share of state-employed physicians worked simultaneously in the private sector to earn additional income (Tokat 1998, 45). Furthermore, the occupational status of healthcare professionals who work in the tax-funded preventive and curative outpatient care facilities has changed. Since 2011, they work on a contract basis and are reimbursed through a mixture of salary and fee-for-services reimbursement (World Bank 2013).

In sum, as regard to the ownership of and state control over the hospital sector, Turkey shares key characteristics with the National Health Service Model. The same observation can be made with regard to the reimbursement of doctors providing secondary care. Both traits suggest a high level of state control over inpatient care facilities. However, in the outpatient care sector, a strong mixture of formal and informal reimbursement modes highlights the coexistence of public and private providers, which sets the Turkish case apart from the ideal type as well as the prototypical cases of Italy and the UK.

The data analyzed above suggests a significant shift in hospital ownership from state to market actors since the AKP came to power. Additionally, recent shifts in the reimbursement procedures of outpatient care physicians need to be taken into account to paint a more comprehensive picture of changes in the style of state regulation over healthcare providers in Turkey. I address these issues in more detail in the second part of this study.

3.5 Organization and development of the delivery system

Schieber outlines four characteristics essential for the organization and development of healthcare delivery systems: resource commitment, quality assurance mechanisms, the level at which healthcare provision is regulated, and the general legal structure. However, he does not present related indicators and neglects the organization dimension in the construction of ideal types.

With regard to resource commitment, Schieber stresses that the nature of health budgets affects the overall cost, reimbursement, and quality of care. In this context, National Health Service countries, in general, exert a high level of control over healthcare expenditure by setting strict budgets on healthcare at the central level, as found in the UK, or at the regional level, as found in Italy.

In Turkey, the overall health budget is also set by the central government, however, it is open-ended and there is the possibility for overshooting. Furthermore, the central government in Turkey has had to repeatedly offset financing gaps at social security institutions. While the central government has implemented capped hospital budgets for cost containment, only hospitals owned by the MoH used to be affected, however, since a 2006 reform capped budgets were extended to all public hospitals.

Nevertheless, the general health budget set by the central government still remains open-ended (OECD and World Bank 2008, 123-24).

In sum, despite policies designed to contain costs, such as the introduction of a purchaser and provider split, and stricter hospital budget control, current financing of the Turkish healthcare system remains unsustainable. Insurance premiums only partially cover healthcare expenses, which results in the need for transfer payments from the central budget to social security and healthcare institutions.

As regard the assurance of quality of care, Schieber highlights the shortfall in international comparison models. In fact, it was not before 2002 that the OECD launched a Healthcare Quality Indicators project aimed at measuring and comparing the quality of health service provision. Accordingly, little cross-national data is available, making it difficult to assess the impact of specific factors on the quality of health services (Carinci et al. 2015). Unfortunately, the quantitative indicators used by the OECD data on Turkey are not available and, therefore, Turkey’s performance as regard quality assurance in healthcare is not compared at this point.

In terms of the level on which healthcare provision is regulated, Schieber outlines that resource development and distribution policies play a significant role. As discussed in Chapter 2, the Turkish central state plays a significant role in that it determines the budget for healthcare. It also exerts a high level of control over the hospital sector when the following indicators are introduced: “authority to open new hospitals” and “authority to recruit hospital staff”. Here, to a certain degree, similarities emerge between Turkey and the countries of the National Health Service Model. Unfortunately, cross-national data is only available for 2008/09, which does not allow for a comparison over time.

Table 10
Authority to open new hospitals

	Authority to open new hospitals, years 2008/09	Authority to recruit hospital staff, years 2008 and 2009
France	--	--
Germany	Regional government	Hospital management
Italy	Central government	Central or sub-national government
Turkey	Central government	Central or sub-national government
UK	Central government	Hospital management
USA	Regional and central government	Hospital management

Source: Paris et al. 2010.

Schieber remains rather vague in his claim that a country’s legal structure has an effect on healthcare. He stresses that anti-trust, medical practice, and insurance laws have an effect on the organization of healthcare delivery. However, he does not mention any indicators to measure this effect. Accordingly, I neglect this aspect of the dimension of organization and development of healthcare systems.

3.6 Interim results

The classification in Schieber's typology reveals, that in terms of financing procedures and eligibility criteria, the Turkish healthcare system stands apart from ideal types and real types discussed. No other country exhibits such a distinct mixture of public financing sources. At the same time, high levels of out-of-pocket payments suggest an extraordinarily high level of social risks and financial burden on the family. However, since the AKP came to power, coverage has reached universal levels and the share of out-of-pocket payments has been significantly reduced. These developments suggest a substantial decrease in the role of the family and a general shift in the actor constellation in the financing dimension of the Turkish healthcare system.

When focusing on the dimensions of benefit provision, reimbursement procedures, and organization, Turkey partly resembles the countries of the National Health Service Model. Primary care is free of charge and the state owns a major share of hospital beds. Furthermore, cross-national comparison shows that the central government exerts a high level of control over the healthcare sector. However, the growing share of private hospital beds over the last decade suggests a departure from the National Health Service Model in the dimension of benefit provision.

In congruence to the historical institutional analysis, the findings of this chapter further validate the claim that the state traditionally exerts a high level of hierarchical control over healthcare providers. Here, the analyzed data does not suggest a significant change in the style of regulation since the AKP came to power.

Furthermore, this chapter has delivered additional evidence for the outstanding role of the family in the Turkish healthcare system. However, based on the indicators offered by Schieber, the family, as a key actor in the Turkish healthcare system, seems to have lost importance.

In sum, the Turkish healthcare system features characteristics from the National Health Service Model and the Social Insurance Model. When focusing on the changes over the last decade, the classification in Schieber's typology reveals the magnitude of the Turkish healthcare system's transformation. Financing has visibly shifted from government to social insurance funding, and the share of out-of-pocket payments has dropped significantly. The introduction of compulsory insurance has increased the coverage of healthcare to universal levels. At the same time, a shift toward healthcare provision through market actors can be observed. These developments further substantiate the claim that the Turkish healthcare system has been in a transformation process since the AKP came to power.

Up to now I have shown that the institutionalization of the Turkish healthcare system stands apart from the experiences of the mature welfare states in Western and Northern Europe. Until recently, the Turkish healthcare system was characterized by a strong reluctance of the state to engage in healthcare financing, provision, and regulation. Healthcare policies excluded a large share of the population and contributed to social inequity and fragmentation. While civil society actors were

strictly controlled by the state, with market actors playing a marginal role, large segments in society relied on their family's capacity and willingness to finance and provide medical care.

My preliminary findings suggest that the Turkish healthcare system has undergone a significant transformation since the AKP came to power. The reforms implemented within the framework of the HTP appear to have changed how healthcare is financed, provided, and regulated. Accordingly, the data which I have analyzed up to now, indicates a maturing of the Turkish welfare state in that it has established institutionalized forms of social protection that aim at the protection of all citizens from social risks on the basis of rights (comp. Esping-Andersen 1990; Moran 2000). However, with regard to some of its key traits, the healthcare system in Turkey continues to differ from its counterparts in mature European welfare states. In order to better understand how healthcare policy, and the actor constellation which constitutes the Turkish healthcare system, have changed under the AKP government, an in-depth analysis is necessary, which I provide below.

4. Research design

In this thesis, I examine the institutional transformation of the Turkish welfare state. More specifically, I analyze how healthcare policies and the healthcare system, defined as the actor constellation which finances, provides, and regulates healthcare, have changed under the AKP government.

By focusing on the Turkish case, I contribute to the literature on the role of actors and institutions in healthcare policy and politics. Outcomes of recent healthcare reforms, such as the impressive expansion of the coverage of the Turkish healthcare system, have triggered my research interest. However, I do not analyze the outcomes of healthcare policy reforms. Instead, I explore how the interdependency of various institutions and political ideas manifest in changing medical care arrangements in Turkey (compare Marmor and Wendt 2012, 11).

In the first three chapters, I have consolidated the research questions of this thesis through a thorough review of the historical institutional development of the Turkish healthcare system and I have outlined its key characteristics through a classification in the typology developed by Schieber. In this chapter, I present the theoretical approach and hypotheses of my thesis as well as the analytical framework and methodology.

4.1 Theoretical approach, research questions, and hypotheses

As I have already shown, the modernization of medical care arrangements in Turkey has, until recently, followed a path that stood apart from the experiences of the mature welfare states in Europe. The state engaged in healthcare as part of a nation-building project. The primary healthcare policy goal was the integration of specific groups in society into this project. Although the institutional origins of the Turkish welfare state can be traced back to the late Ottoman Empire, a mature welfare state that protects all citizens on the basis of social rights did not evolve in the 20th century. Instead, I claim that prior to recent reforms, fragmented and exclusionary governmental healthcare policies excluded large segments of society and strengthened the role of the family in healthcare financing and provision.

The classification of Turkey in Schieber's typology indicates that the Turkish healthcare system has undergone a comprehensive transformation since the AKP came to power. However, while Turkey is closing the gap with mature European welfare states, I have also shown that unique characteristics, such as the strong role of the family in healthcare financing and the high level of state regulation over healthcare providers seem to persist. These characteristics in particular set the Turkish case apart from other insurance-based healthcare systems in corporatist welfare states.

From these findings I derive a number of research questions which focus on the nature and scope of changes in healthcare policy and the Turkish healthcare system: What has changed in healthcare policy

since the AKP came to power? How profound are these changes? How do they affect the actor constellation which constitutes the Turkish healthcare system? Do policy changes imply a new role of the state in healthcare and welfare provision? Does a new type of modern healthcare system emerge in Turkey which differs from its counterparts in Europe? How do changes in healthcare policy and politics and the AKP relate to the general transformation of political institutions in Turkey?

In order to answer these questions, the research design of this thesis is structured by theoretically informed hypotheses that elaborate on the historical institutionalist approach and the regime approach. The historical institutionalist approach enables us to better understand the larger picture and offers a comprehensive framework for the analysis of institutional changes under the AKP government by putting them into context with the long-term transformation of healthcare institutions in Turkey. It explains why established healthcare institutions change at a certain point in time and conceptualizes links between the AKP healthcare reforms and the broader political and socio-economic environment.

The healthcare reforms of the HTP were implemented in an environment marked by fundamental socio-economic and political changes. I argue that the rise of the AKP and its conquest of the state apparatus and veto institutions over the last decade constitutes a critical juncture defined as “a period of significant change, which typically occurs in distinct ways in different countries (or other units of analysis) and which is hypothesized to produce distinct legacies” (Collier and Collier 1991, 29). Accordingly, I argue that recent healthcare policy reforms constitute a paradigm shift and a significant transformation in the actor constellation that constitutes the Turkish healthcare system. My goal is to analyze this transformation which may mark the beginning of a new institutional legacy in healthcare policy in Turkey.

The regime approach, complemented by principles of governance and feminist approaches, offers a comprehensive theoretical and methodological framework for the analysis of the transformation of healthcare policy and the actor constellation that constitutes the Turkish healthcare system. It stresses changes in the institutional links between the state, the market, non-governmental actors, and the family in the realm of healthcare, as well as the ideological underpinnings of these institutional arrangements (Esping-Andersen 1990; Wendt 2009). Based on these theoretical underpinnings, I posit the following hypotheses:

Main hypothesis

The political hegemony of the AKP government constitutes a critical juncture, which has led to a paradigm shift in healthcare policy and a system change in the actor constellation that constitutes the healthcare system of contemporary Turkey.

Sub-hypothesis 1

The healthcare reforms of the AKP led to a system change in the actor constellation that constitutes Turkey's healthcare system.

Sub-hypothesis 1.1

The reforms of the AKP strengthen the role of the state as a regulator in Turkey's healthcare system.

Sub-hypothesis 1.2

The reforms of the AKP strengthen the role of market actors as providers in Turkey's healthcare system.

Sub-hypothesis 1.3

The healthcare reforms of the AKP strengthen the role of non-governmental actors as financiers in Turkey's healthcare system.

Sub-hypothesis 1.4

The healthcare reforms of the AKP decrease the role of the family in healthcare financing and provision.

Sub-hypothesis 2

The healthcare reforms of the AKP lead to a paradigm shift in healthcare policy.

Sub-hypothesis 2.1

The healthcare reforms of the AKP led to changes in policy goals, instruments, and instrument settings.

Sub-hypothesis 2.2

In the realm of healthcare, the reforms of the AKP led to the emergence of a mature welfare state which protects its citizens from risks related to sickness on the basis of social rights.

Sub-hypothesis 2.3

In order to protect all citizens from social risks related to sickness, the state increasingly regulates the role of the family, the market, and non-governmental actors in the financing and provision of healthcare.

Sub-hypothesis 2.4

The state regulates the roles of the market, non-governmental actors, and the family through hierarchical steering. With regard to the mode of governance, policy changes under the AKP government are path-dependent.

In the following I introduce the analytical framework that allows these hypotheses to be tested.

4.2 Analytical framework and methodology

Scholars who bridge the gap between welfare state and healthcare system analysis have shown that healthcare systems are more than subdomains of the welfare state. They highlight that the specific interlinkage between healthcare institutions and other institutions of the state, the market, and non-

governmental actors demand an adaption of the theoretical and methodological tools of welfare state analysis (Moran 2000, 139).

Accordingly, the hypotheses of this study are discussed based on an analytical framework, which conceptualizes changes in the role of political actors and institutions in healthcare policy. Here, I elaborate on two existing frameworks: First, the typology developed by Claus Wendt et al. which highlights cross-national variations as well as internal changes in the role of actors and modes of governance within different healthcare systems (Wendt et al. 2009). Second, Peter Hall’s conceptualization of policy change (Hall 1993).

Wendt et al. distinguish between three different dimensions of healthcare systems: financing, provision, and regulation. In cross-national comparison, different constellations of actors emerge in these dimensions that constitute the respective healthcare system. More specifically, they identify three groups of actors: the state, the market, and non-governmental actors (Wendt et al. 2009, 71).

The review of the theoretical and institutional aspects of the Turkish healthcare system and the identification of its key characteristics through the classification in Schieber’s typology, suggest that in the Turkish context the family plays a significant role. While a rich literature exists surrounding the importance of the family in welfare provision, its role in healthcare systems has been largely neglected so far. Accordingly, I elaborate on those feminist scholars that call for the integration of the gender dimension into mainstream welfare state research and I include the family as a fourth actor in the healthcare mix (Daly and Lewis 2000; Orloff 1993).

Healthcare systems can be classified according to which actor dominates these three dimensions outlined above. The result is a simple scheme, which entails four ideal type and a multitude of mixed-type healthcare systems.

Table 11
Types of healthcare systems

System type	Financing	Provision	Regulation
State-based healthcare system	State	State	State
Market-based healthcare system	Market	Market	Market
Societal-based healthcare system	Societal	Societal	Societal
Family-based healthcare system	Family	Family	Family
Market-based mixed healthcare system	State	Market	Market
Pure mixed healthcare system	Family	Market	State

Source: Own depiction based on Wendt et al.

This analytical framework has two capacities. First, through classification, it allows for cross-national comparisons of multiple cases in order to highlight national traits but also similarities among different

healthcare systems. Second, it allows for the measurement of internal changes within different healthcare systems over time (Wendt et al. 2009, 82).

I do not attempt a comparative analysis of the Turkish healthcare system. Accordingly, it is the conceptualization of internal change that makes Wendt et al.'s analytical framework relevant for my thesis. Nevertheless, while my empirical focus is on the Turkish case, the analytical framework allows me to put findings regarding the transformation of the Turkish healthcare system into perspective and to highlight the relevance of the Turkish case for comparative welfare analysis.

Wendt et al. differentiate between three levels of change. Based on their concept, a system change occurs when a shift in the actor constellation in one or more dimensions of a healthcare system leads to a changeover in the predominant actor, i.e. a state-based mixed type transforms into a market-based-mixed type healthcare system. An internal system change occurs when a formerly predominant actor loses its main role in one dimension but remains strong in the other two, i.e. a state-based type transforms into a state-based mixed type. An internal change of levels occurs when we observe a transformation within one or more dimension which does not lead to a shift in the predominant actor (Ibid., 83).

This concept strongly resembles the analytical framework developed by Peter Hall, a milestone in the literature analyzing policy change. Hall identifies three different components of policy: political goals that underpin the policy, instruments to implement a policy, and different settings of policy instruments. Based on these components, he differentiates between three levels of change. A first order change occurs when settings of policy instruments are altered but the overall policy goals and instruments remain the same. A second order change occurs when policy instruments and settings are altered but the policy goals stay in place. A third order change, or paradigm change, comprises a radical shift in the hierarchy of goals that underpin a policy (Hall 1993). Critics argue that Hall's model lacks the capacity to integrate policy outcomes and that a clear-cut differentiation between the categories is difficult. However, in the context of this thesis, Hall's analytical framework is a valuable heuristic device to differentiate between levels of policy change (compare Powell 2008, 12; Haberecht 2015, 48-49).

While Wendt et al. focus on healthcare systems and Hall on public policy, both aim to answer two simple questions: what has changed and to what degree have they changed? As my research interest lies on the transformation of healthcare policies as well as the actor constellation that constitutes the Turkish healthcare system, the analytical framework of my study combines the two concepts.

Firstly, I examine if the hierarchy of healthcare policy goals, instruments of policy implementation, as well as their settings, have changed in the three dimensions of the Turkish healthcare system since the AKP came to power. Employing Hall's three categories of system change as a heuristic device, I qualitatively analyze the findings of this thesis. My objective is to categorize the changes in healthcare

policies under the AKP government as first, second, or third order changes.

Secondly, I examine how the actor constellation in the three dimensions of the Turkish healthcare system has changed. Based on the categorization of Wendt et al., I analyze whether a system change, an internal system change, or an internal change of levels in healthcare politics, occurred under the AKP government.

Given the institutional complexity of national healthcare systems, comparative studies in the field commonly face a trade-off between the theoretical depth of their methodological framework and the number of countries that are analyzed (Marmor and Wendt 2012, 15). As this study focuses empirically on a single case, an in-depth analysis is possible. In order to achieve this, I employ the methodological framework integrated in the methodology of the SHA 2011, which has been co-developed by the OECD, Eurostat, and the WHO (OECD et al. 2011), as well as the complementary “SHA 2011 Framework for Accounting Healthcare Financing” (OECD and WHO 2014). The SHA 2011 focuses on the internal workings of healthcare systems and its aim is to provide an accounting tool for the assessment and monitoring of the economic performance of healthcare systems (Ibid., 6).

Employing the SHA 2011 for the analysis of the Turkish healthcare system offers three advantages. First, it provides analytical concepts and sets of indicators, which ensure the comparability of its findings and the systematic analysis of the transformation of the Turkish healthcare system over time. Second, the SHA 2011 makes a distinction between financing schemes and institutional units, hereafter referred to as financing institutions, which allows a better understanding of the complexity of the actor arrangements in healthcare financing in Turkey (Ibid., 7). Third, the SHA 2011 considers households as both financing agents and healthcare providers. This distinction is helpful for the analysis of the family’s role in healthcare financing and provision (OECD et al. 2011, 46-47).

The integration of the concepts and indicators of the SHA 2011 into Wendt et al.’s analytical framework allows for a comparable picture of the Turkish case to be painted and at the same time enables us to better understand the social and political embeddedness of the Turkish healthcare system and the transformation of the roles of the state, the market, non-governmental actors, and the family in healthcare financing, provision, and regulation.

The analysis of the financing dimension in Chapter 5 comprises two sections. In the first section, I analyze the levels and functional distribution of healthcare expenditure in Turkey based on key indicators employed by the SHA 2011. Complementary to the classification of Turkey’s healthcare system in Schieber’s study, this section aims to highlight key characteristics of healthcare financing and the trajectory of its transformation since the AKP came to power. In particular, the analysis of expenditure data helps define the family’s role in healthcare financing. This section, therefore, lays the groundwork for the second section in which the hypotheses of this thesis are discussed. Methodologically, this section is based on the secondary analysis of statistical healthcare data

provided by the OECD, Eurostat, Turkish Statistical Institute (*Türkiye İstatistik Kurumu*, TurkStat), the Turkish MoH, as well as several case studies on healthcare expenditure and household budget surveys from Turkey.

Elaborating on these findings, the second section highlights healthcare policy changes and shifts in the actor constellation in the financing dimension of Turkey's healthcare system. The analysis is structured by three concepts introduced by the SHA 2011 to describe the institutional structure of different health financing systems. Firstly, financing schemes are the basic components of health financing systems as they determine how people can access healthcare. Financing schemes differ substantially with regard to modes of participation and benefit entitlement, fund raising, and pooling mechanisms, as well as the benefits packages they provide. Secondly, financing institutions are the institutional units of the economy which provide revenues to financing schemes. Financing schemes may be financed by one or more financing institution. Thirdly, financing agents are the institutional units that administer and operate the schemes in practice (OECD and WHO 2014, 7).

Accordingly, I categorize the healthcare schemes that existed prior to the AKP government and compare these to the schemes of contemporary Turkey. I examine changes in the actor constellation within the respective schemes by categorizing financing agents and financing institutions as institutions associated with the state, the market, non-governmental actors, or the family.

Furthermore, healthcare financing schemes as analytical categories are helpful in revealing the hierarchies of policy goals that underpin healthcare systems. Based on the ideal types of Schieber's typology, Wendt distinguishes between three public policy goals in healthcare systems of mature welfare states. The main policy goal in healthcare systems of the National Health Service Model is to create access to healthcare for the entire population. Policies in healthcare systems of the Bismarck Model primarily aim to create the institutional conditions that allow for the compensation of risks and costs related to sickness. These policies focus on the working population which is capable to socially secure itself through insurance premiums. As discussed, the Private Insurance Model is marked by the dominant role of for-profit actors and a high level of patient sovereignty. Wendt states that in order to increase social equity, public policies in these healthcare systems predominantly aim at the provision of rudimentary healthcare care services. Target group of these policies are mostly underprivileged groups in society (Wendt 2009, 78-79).

In addition to the policy goals outlined by Wendt, I take two additional policy goals into account. Firstly, I argue that public policies may be underpinned by the premise that an individual's access to care should be based on his or her market position. Accordingly, the policies' primary goal is the commodification of healthcare services. Secondly, policies may be based on the assumption that the patient's family is responsible for his or her healthcare. Hence, public policies aim to strengthen the capacity of the family to finance and provide healthcare.

Wendt outlines that in congruence to the welfare regime models described by Esping-Andersen, the dominant policy goals of the ideal type healthcare system are underpinned by different political ideologies, namely liberalism, corporatism and social democracy. However, he stresses that the complexity of actor arrangements and the diversity of principles and ethic values encoded in healthcare institutions make it difficult, but not impossible, to empirically identify different types of healthcare regimes (Ibid., 77).

Similarly, it needs to be emphasized that the policy goals described above refer, to varying degrees, to the “principle of subsidiarity”, which originates in Catholic social teaching and postulates that political authorities should only interfere in the private sphere if individuals or small communities such as the family are incapable of acting independently (Misra and Moller 2005, 6).

In fact, real type healthcare systems commonly comprise a variety of different healthcare financing schemes which are often underpinned by different policy goals. These schemes commonly cover specific groups in society and determine who has access to what kind of care. In order to reveal the hierarchy of policy goals that structure the Turkish healthcare system, I take into account the level of coverage as well as access to and utilization of services financed by the respective schemes.

The analysis of the transformation of healthcare financing in Turkey is methodologically based on the qualitative analysis of key legislation. Accordingly, I examine the relevant laws of the early 2000s as well as current legislation. Additionally, I analyze healthcare data provided by the OECD, Eurostat, TurkStat, the Turkish MoH, as well as several case studies.

In Chapter 6, I analyze policy changes and shifts in the actor constellation within the provision dimension of Turkey’s healthcare system. The analysis is structured by categories defined by the SHA 2011. In particular, I distinguish between different provider functions: (i) curative care; (ii) rehabilitative care; (iii) long-term healthcare; (iv) medical goods; and (v) preventive care. Within these functions, I differentiate between four modes of provision: (i) inpatient care; (ii) day care; (iii) outpatient care; and (iv) home care (OECD et al. 2011, 389-90). In order to categorize healthcare providers, I use ownership and profit-orientation as key indicators. The chapter is based on the qualitative analysis of key legislation; expert interviews; the secondary analysis of statistical data on healthcare providers published by Turkish state institutions, mostly by the MoH; and international actors, such as the OECD and the World Bank; as well as the secondary analysis of relevant academic literature.

In Chapter 7, I provide an analysis of the transformation of the regulation of healthcare financing and provision in Turkey. Based on Wendt et al., I examine three levels of healthcare governance: (i) the relationship of patients to financing agents; (ii) the relationship of financing agents to service providers; and (iii) the relationship of patients to service providers (Wendt et al. 2009, 80). I examine three questions on each of these levels: Who is in charge of regulating and controlling these

relationships? What is the goal behind the regulation of these relationships? Which instruments are used to regulate these relationships? Methodologically, the analysis of the transformation of the regulation dimension of Turkey's healthcare system is based on the analysis of key legislation and secondary literature analysis.

In Chapter 8, I summarize the findings of the analysis of the three dimensions of the Turkish healthcare system and discuss the validity of the hypotheses. The main hypothesis is considered valid if we can observe a paradigm change in healthcare policies, defined as a radical alteration in the hierarchy of policy goals; and a system change in healthcare politics, defined as an alteration in the healthcare system's predominant actor.

II. The Turkish healthcare system in transformation

In this part I provide an in-depth analysis of how the roles of political and societal institutions, as well as actors in healthcare policy and the healthcare system of Turkey, have transformed since 2003. My research is structured by a new analytical framework that elaborates on the regime approach and allows me to examine policy changes and shifts in the actor constellation of the Turkish healthcare system. This part is divided into four chapters. In Chapters 5 to 7, I examine the transformation of the Turkish healthcare system according to its different dimensions, namely healthcare financing, provision, and regulation. In the final chapter, I summarize the findings of this thesis and discuss the validity of the main hypothesis that the political hegemony of the AKP government constitutes a critical juncture which has led to a paradigm shift in health care policy and a system change in the actor constellation that constitutes the healthcare system of contemporary Turkey.

5. The transformation of healthcare financing

In this chapter, I examine changes in the financing dimension of the Turkish healthcare system since the AKP came to power. The chapter is divided into two sections. In the first section, I identify the key characteristics of healthcare financing in Turkey and trace the trajectory of its transformation by analyzing shifts in healthcare expenditure. In the second section, I analyze changes in the policy goals that underpin the existing healthcare schemes and examine if the actor constellation in the financing dimension of the Turkish healthcare system has changed.

5.1 Healthcare expenditure

Healthcare expenditure can be defined as the economic resources spent on goods and services related to the following healthcare functions: (i) curative care; (ii) rehabilitative care; (iii) long-term care; (iv) ancillary services; (v) medical goods; (vi) preventive care; and (vii) governance and administration (OECD et al. 2013, 38). For Turkey, two studies by Mehmet Tokat are especially helpful for sketching a broad picture of healthcare expenditure and financing prior to the 2000s (Tokat 1993; 1998). However, when considering the complexity of Turkey's healthcare system and the multitude of its funding sources, the high level of informal and formal out-of-pocket payments, and deficits with regards to methodology used for its collection, the validity of official expenditure data is brought into question (Tatar et al. 2011, 38). Furthermore, data on health expenditure from Turkey is generally based on MoH estimates. Only one study was conducted on Turkey for the years 1999 and 2000 employing the 1.0 Version of the OECD's System of National Health Accounts (MoH 2004). Data on out-of-pocket expenditure is more reliable as it is based on household budget surveys that employ the Eurostat methodology, however, the lack of reliable data overall makes a detailed breakdown of the changes in level and structure of healthcare expenditure impossible. Accordingly, based on SHA 2011 indicators, I use expenditure data from Turkey and other OECD countries to highlight characteristics of healthcare financing in Turkey as well as its transformation over time.⁸⁰ My aim is to complement the findings of the classification of Turkey in Schieber's typology and, in particular, shed more light on the family's role in healthcare financing.

⁸⁰ In particular, I will examine data from countries that have been described in the literature as exemplary for the classical ideal types of healthcare systems first outlined by Schieber. Furthermore, I will include data from the Southern European EU member states. A number of studies highlight similarities between the Turkish welfare state and these countries (Buğra and Keyder 2006; Grütjen 2008; Gough 1996).

5.1.1 Changes in the level of healthcare expenditure

Common indicators used to compare healthcare expenditure are share of gross domestic product (GDP), per capita values, and converted values using purchasing power parity (PPP) or exchange rates (OECD et al. 2011, 345). A comparison based on OECD data shows that Turkey has lagged considerably behind other OECD countries. In 2015, most OECD countries spent between 9 and 11 percent of their GDP on healthcare. In contrast, the share of healthcare expenditure in Turkey in 2015 amounted to 5.2 percent, the lowest of OECD countries.⁸¹ At the same time, Turkey's GDP has only marginally increased since the AKP came to power. However, it is important to note that Turkey's GDP per capita increased from 8,807 U.S. dollars in 2003 to 19,917 U.S. dollars in 2015 (OECD Health Statistics 2016).

Table 12

Total current expenditure on health as a percentage of GDP

	1970	1980	1990	2000	2010	2015
Germany	5.7	8.1	8.0	9.8	11.0	11.1
Greece	--	--	6.1	7.2	9.9	8.2
Italy	--	--	7.0	7.6	9.0	9.1
Netherlands	--	6.6	7.1	7.1	10.4	10.8
Portugal	2.3	4.8	5.5	8.4	9.8	8.9
Spain	3.1	5.0	6.1	6.8	9.0	9.0
Sweden	5.5	7.8	7.3	7.4	8.5	11.1
Switzerland	4.9	76.6	7.4	9.3	10.5	11.5
Turkey	--	2.4	2.5	4.7 (6.4)*	5.3	5.2
United Kingdom	4.0	5.1	5.1	6.3	8.5	9.8
United States	6.2	8.2	11.3	13.2	16.4	16.9

Notes: * estimates based on SHA

Source: MoH 2004; OECD Health Statistics 2016.

The discrepancy between Turkey and other OECD countries becomes more tangible when comparing per capita expenditure for health. In 2015, Turkey spent only 974.80 U.S. dollars per capita on health, putting it second from bottom of OECD countries, with only Mexico spending less. The OECD average is 3,405.00 U.S. dollars. Since the beginning of the HTP in 2003, per capita health expenditure has increased from 656.80 U.S. dollars to 974.80 U.S. dollars (OECD Health Statistics 2016).

⁸¹ Estimates of healthcare expenditure based on the OECD's SHA for 2000 are significantly higher than the official numbers (MoH 2004). Additionally, the methodology used by TurkStat to calculate GDP changed in the late 1990s. According to the old calculations, Turkey's GDP was significantly lower and in consequence health expenses accounted for a much higher share (6.6 percent in 2000). As Tatar et al. outline, the methodological changes in calculating Turkey's GDP triggered a shift in the debate among policy makers toward increasing resources for healthcare (Tatar et al. 2011, 38).

Table 13

Total health expenditure per capita in U.S. dollars, constant PPPs, OECD base year, 1970-2015

	1970	1980	1990	2000	2010	2015
Germany	1,219.40	2,282.40	2,774.70	3,536.40	4,358.60	4,772.30
Greece	--	--	1,266.70	1,815.20	2,855.30	1,994.10
Italy	--	--	2,095	2,655.80	3,108.20	2,954.10
Netherlands	--	1,765	2,235.30	2,895.50	4,671	4,885.60
Portugal	237	709.10	1,100.30	2,153.80	2,645.70	2,319.40
Spain	448.70	913.80	1,444.20	2,049.60	2,917.90	2,896.90
Sweden	1,168.30	1,953.60	2,182.60	2,656.40	3,543.60	4,906.90
Switzerland	1,672.30	2,505	3,251.60	4,344.60	5,371.50	6,062.30
Turkey	--	182.30	249.50	575.20	852.70	974.80
United Kingdom	656.10	1,101.80	1,344.10	2,044.20	3,036.10	3,767.40
United States	1,452.60	2,363.70	4,277.90	5,635.30	7,929.40	8,714.90

Source: OECD Health Statistics 2016.

While the data needs to be treated with caution, it is evident that Turkey still lags far behind the healthcare systems of Western Europe. Nevertheless, expenditure has increased significantly over the last two decades as an apparent consequence of new healthcare policies. However, this increase tells us little about the roles state institutions, market and non-governmental actors, and the family play in healthcare financing, and how far their relationships have changed over time.

5.1.2 Changes in the structure of healthcare expenditure

Data on the functional distribution of current health expenditure appears more useful as it allows specific traits of healthcare financing in Turkey to be highlighted. The SHA 2011 distinguishes broadly between the costs of individual and collective healthcare. Individual healthcare includes the functions (i) curative care; (ii) rehabilitative care; (iii) long-term care; (iv) ancillary services; and (v) medical goods. Collective healthcare expenditure includes costs of prevention and public healthcare services, as well as costs related to governance and administration (OECD et al. 2011, 37).

Table 14 shows health expenditure by function for the years 2000 to 2012. The data is based on MoH estimates and as such needs to be treated with caution. However, it allows for a broad assessment of the changes in functional distribution of healthcare expenditure and its transformation over time.

Table 14

Health expenditure in Turkey by function as a percentage of total expenditure on health, years 2000 to 2012

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Hospitals and Providers of ambulatory healthcare	62.3	55.5	52.9	54.9	55.3	54.9	55.5	57.7	58.8	57.8	61.3	63.7	63.7
Home nursing and residential care facilities	0	0.4	0.3	0.3	0	0	0	0	0	0	0	0	0.5
Retail sale and other providers of medical goods	27.9	36.4	38.6	37	35.8	37	36.1	34.5	33.7	36.2	32.9	31.1	26.5
Provision and administration of public health programs	0.4	0.4	0.4	0.9	0.9	0.8	0.8	0.8	0.8	1.3	1.1	0.9	3.5
General health administration and insurance	2.1	2.1	2.2	2.1	0.9	0.9	0.8	0.8	0.9	0.5	0.5	0.5	0.9
Other	7.3	5.2	5.5	4.9	7.1	6.3	6.8	6.2	5.9	4.2	4.2	3.9	5.0

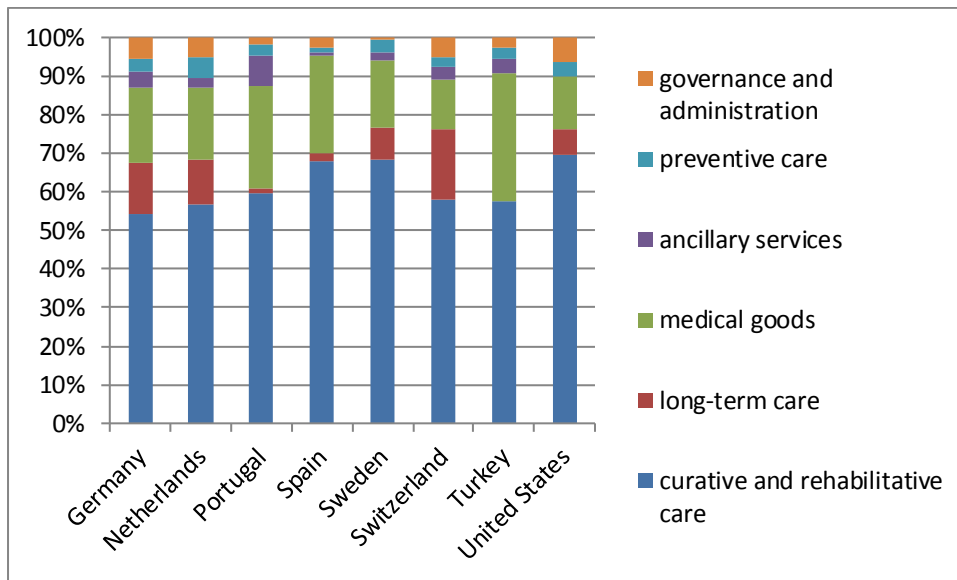
Source: TurkStat online.

Taking the SHA 2011 categories as a reference, the data shows that healthcare expenditure in Turkey is mainly for individual healthcare, while expenditure for collective healthcare has been negligible. Curative care provided in hospitals and ambulatory healthcare facilities, as well as medical goods, account for the lion's share of healthcare expenditure, amounting to more than 90 percent of total expenditure since 2000. Through the 2000s we can observe a significant increase in the share of expenditure for curative care. The costs for medical goods increased significantly throughout the mid-2000s and peaked in 2009. However, since then we can observe a rapid decline in the cost of medical goods. Most striking is the absence of data for long-term care expenditure before 2012, and an increase in expenditure for public health programs in the same year.

Changes in healthcare expenditure since the 2000s point to the impact of the AKP reforms. As briefly discussed in Chapters 2 and 3, healthcare reforms over the last decade placed strong emphasis on the restructuring and improvement of outpatient and inpatient curative care. More recently, public programs have focused on the provision of long-term care in domestic settings, as well as an increase of public health programs, which may explain the increase in expenditure in 2012. These reforms are discussed further in Chapters 6 and 7.

When the functional distribution of healthcare expenditure is compared with other OECD countries, the high cost of medical goods and the absence of data for long-term care stand out (Figure 3).

Figure 3
Current expenditure on healthcare by function, year 2000 or closest year available



Notes: No data available for Greece and the UK.
 Source: OECD Health Statistics 2016.

The comparatively high expenditure on pharmaceuticals in Turkey has been highlighted by a number of studies.⁸² In 2000, expenditure on medical goods in Turkey was the highest among the countries under discussion, amounting to 29.1 percent of total health expenditure, followed by Portugal with 26.8 percent, and Spain with 25.5 percent. According to Liu et al., four factors contribute to the high share of expenditure on medical goods in Turkey: First, high international market prices; second, the structure of state subsidies for pharmaceuticals; third, high levels of self-medication due to the low number of doctors and insufficient coverage of the healthcare system; and fourth, many hospital patients in Turkey are instructed to buy medication out-of-pocket. In the SHA, medication given in hospital settings is commonly counted as expenses for services of curative and rehabilitative care, whereas a significant share of the medication given in Turkish hospitals is sold in pharmacies, and as such counts as medical goods (Liu et al. 2005). Two of these factors - self-medication and out-of-pocket payments for pharmaceuticals in secondary care - are especially important for this thesis as they highlight how healthcare policies affect the role of the family in healthcare financing and provision.

Data from 1999 and 2000 suggests that 32.9 percent of out-of-pocket payments in Turkey were spent on medical goods (MoH 2004, 25). Out-of-pocket payments for pharmaceuticals place a particularly high burden on Turkish citizens without health insurance. For the uninsured, pharmaceutical expenses account for 55 percent of formal, and 82.5 percent of informal out-of-pocket payments (Tatar et al.

⁸² Some examples are: World Bank 2003a; World Bank 2003b; Liu et al. 2005; Tatar et al. 2007; MoH 2004; OECD and World Bank 2008; Tatar et al. 2011.

2007, 1035). One explanation for the high expenditure on pharmaceuticals is that limited access to healthcare leads to higher levels of self-medication and medication by non-health professionals, in particular, family members. It is important to note that self-medication or medication by non-professionals is made possible through public policies. By regulating the pharmaceutical market, state institutions determine the conditions under which the sick can resort to informal care. This issue is addressed further in Chapter 7.

As already mentioned, high out-of-pocket payments for pharmaceuticals in inpatient care contribute to the high burden on households in financing healthcare. In 2002 and 2003, approximately 30 percent of hospital patients purchased their prescribed medication out-of-pocket (Ibid., 1034). This suggests that health personnel working in public settings systematically instruct patients to purchase medical goods which should otherwise be provided free of charge. Accordingly, informal out-of-pocket payments have become an integral part of financing state-owned inpatient care facilities.

The second characteristic trait of healthcare expenditure in Turkey is the lack of an official record of expenses for long-term care, which suggests a prominent role of informal actors. Existing studies in the field have focused predominantly on elderly care with results showing that this is mostly provided by family members (Kalaycıoğlu and Rittersberger-Tılıç 2000; Saka and Varol 2007). Additionally, in wealthier segments of society, non-registered for-profit caregivers, who are financed through informal household payments, also play a significant role (Zencir 2005). These findings suggest that the Turkish family is both the key financing agent and provider of long-term care. I examine this claim further in Chapter 6.

A more accurate and detailed breakdown of healthcare expenditure data for Turkey is only available for the year 2000. Table 15 shows the results of this study based on the OECD's SHA 1.0. In comparison to MoH estimates, significant differences stand out with regard to the cost of curative primary and secondary care.

Table 15
Current healthcare expenditure by financing agent as a percentage, year 2000

Financing Agent	Public Sector	Private sector	Total expenditure
Total current expenditure	61.7	38.3	100
Curative care	30.4	19.2	49.6
Rehabilitative care	0.8	0.1	0.9
Long-term nursing care	--	--	--
Ancillary services	0.7	2.8	3.5
Medical goods	18	11.1	29.1
Prevention and public health services	2.3	0.1	2.4
Health administration and health insurance	1.1	1.2	2.3
Other			12.3

Source: MoH 2004.

However, in line with MoH estimates, the data also suggests that prior to the HTP, the overwhelming share of health expenditure was on individual healthcare, more specifically, curative care as well as medical goods. It shows that prior to the HTP, 38.3 percent of healthcare expenditure was by private actors. Given the marginal role of private insurance in healthcare financing, the data shows that more than one-third of the expenditure on curative care and medical goods was made by households.

These findings underline the structural importance of informal healthcare expenditure in Turkey and suggest that formal and informal out-of-pocket payments place a significant financial burden on households. Surprisingly, the current consumption expenditure of Turkish households on healthcare is very low in international comparison.

One of the key indicators used in the literature to measure the financial and social risks related to healthcare spending is the proportion of households with catastrophic expenditure. Healthcare expenditure is defined as catastrophic when it exceeds 40 percent of a household's capacity (Yardımcı et al. 2010, 28). A 2003 study by Ke Xu et al. found that catastrophic health expenditure differs significantly in international comparison, ranging from less than 0.01 percent in the Czech Republic to 10.45 percent in Vietnam. The proportion of households with catastrophic health expenditure in most of the countries referenced in this study is below 1 percent.⁸³ Only Greece and Portugal stand out with 2.17 percent and 2.71 percent respectively (Xu et al. 2003, 113).

Related studies based on data from Turkey show that the share of households with catastrophic health expenditure has decreased steadily over the last decade from 0.75 percent in 2003 to 0.59 percent in 2006, and to 0.48 percent in 2009 (Yardımcı et al. 2014, 185).⁸⁴ As Xu et al.'s study is based on data collected in the mid and late 1990s a cross-national comparison with Turkey becomes problematic. However, the proportion of households in Turkey with catastrophic health expenditure appears remarkably low, especially when taking into account the chronically high levels of out-of-pocket payments, the low coverage of the healthcare system, and the absence of institutions providing long-term care.⁸⁵ In comparison to other countries with similar income levels, Turkey has a significantly lower share of households with catastrophic health expenditure (compare Xu et al. 2003, 113).

Similar to findings from other countries, Turkish urban households, especially those with high levels of education run the lowest risk of catastrophic health expenditure. Access to health insurance appears to be the key protective factor against catastrophic health expenditure (Başar et al. 2012, 6).

⁸³ The proportion of households facing catastrophic expenditure was 0.03 percent in Germany, 0.48 percent in Spain, 0.18 in Sweden, 0.57 in Switzerland, 0.4 percent in the UK and 0.55 percent in the USA.

⁸⁴ Another study based on the 2006 Household Budget Survey put the share of Turkish households with catastrophic health expenditure at 0.6 percent (Yardımcı et al. 2010, 29). See also: Yardımcı et al. 2014; Başar et al. 2012; Sulku and Bernard 2012.

⁸⁵ Regarding the impact of institutionalized long-term care in Turkey, it needs to be highlighted that having a disabled or sick individual in the household is one of the main factors that contribute to catastrophic healthcare expenditure (Başar et al. 2012, 6).

Accordingly, access to free outpatient care, as well as reforms that have increased the coverage of health insurance schemes, may have had a positive effect on risk pooling capacities and decreased the financial burden on individual households.

Most striking in the Turkish context is that poor households, as well as larger households that concentrate in lower income quintiles, run a significantly lower risk of catastrophic health expenditure. Başar et al. argue that larger households are more likely to have multiple earners contributing to its income. This argument is substantiated by the fact that members of larger households are more likely to seek medical assistance when sick (Ibid., 16).

Two other factors are listed in the literature that may contribute to this phenomenon. First, members of poorer households are less likely to seek care from private providers, which are commonly perceived as better but also as much more costly. This claim is substantiated by the fact that out-of-pocket payments in wealthier households are higher when compared to poorer households. In 2003, the poorest quintile of households in Turkey spent 1.44 percent of its monthly expenditure on out-of-pocket health payments, while the richest quintile spent 2.58 percent (Yardımcı et al. 2010, 29).

A second factor that might contribute to low healthcare expenditure in poorer households is their general reluctance to seek professional healthcare. In 2001, only 68 percent of Turkey's poorest quintile sought care when sick (World Bank 2003a, 35). A lack of funds is the main reason the uninsured and Green Card holders did not seek professional care (Tatar et al. 2007, 1038). Similarly, based on micro data from the 2007 European Union Statistics on Income and Living Conditions survey, Yardımcı et al. found that 29.9 percent of the non-insured in Turkey abstain from professional healthcare due to financial barriers, as opposed to 6.1 percent of those covered by public insurance schemes (Yardımcı et al. 2014, 190).

At the same time, a significant share of the population seeks informal care when sick. In 2000, 26.6 percent of the sick in Turkey resorted to self-help or the help of others to overcome a health problem (Tatar et al. 2011, 44). Given that relatives are the key caregivers for the disabled and the elderly, this further substantiates the claim that the family plays a strong role in the provision of medical care.

The claim that poor households in Turkey spend little on healthcare because they avoid professional care is also supported by a study by Erus et al. They found that when poor patients without access to health insurance receive inpatient treatment, out-of-pocket payments increase exponentially to approximately 8 percent of their annual income. In 2011, the average out-of-pocket payments for inpatient care made by those without access to health insurance was 562.50 Turkish lira (272.47 euros) for medical services and 150.00 Turkish lira (72.66 euros) for medication. Considering the minimum

wage was approximately 600.00 Turkish lira (290.64 euros) in 2010, the financial burden for households with a member receiving inpatient care is significant (Erus et al. 2015, 104).⁸⁶

In sum, health expenditure levels have increased since the 1990s, most noticeably since the AKP came to power. However, when considering expenditure per capita, Turkey still lags greatly behind other OECD countries. Data on the functional distribution of current health expenditure reveals a number of characteristics of the actor constellation that constitutes the Turkish healthcare system. The findings indicate that the family plays a significant role in healthcare financing and that the absence of expenditure data for long-term care also suggests that it is a key provider of healthcare. However, recent increases in public expenses for long-term care services indicate policy changes under the AKP. In terms of pharmaceutical and hospital care, analysis of expenditure data suggests that government policies, as well as regulation of state-owned providers, reproduce the family's role in healthcare financing.

By analyzing health expenditure data I have shown that the roles of the state and the family in healthcare financing in Turkey are interwoven. However, it is important to note that we still know very little about the structure of healthcare expenditure in Turkish households and their mechanisms of risk pooling. Especially puzzling is the discrepancy between the high share of private healthcare expenditure and the relatively low burden of household out-of-pocket payments. Here the claim that unpaid family members contribute significantly to healthcare provision would partly explain this phenomenon. At the same time, state regulation of pricing for medical services and goods may contribute to low costs for individual healthcare in Turkey. In the following I attempt to shed light on the actor constellation of the financing dimension of the Turkish healthcare system and its transformation since the AKP came to power.

5.2 Healthcare financing

The findings of the previous chapters suggest a comprehensive transformation in healthcare financing under the AKP government. The classification of Turkey in Schieber's typology has revealed that in the early 2000s, large segments of society were excluded from the public healthcare system. Healthcare financing was characterized by a distinct mixture of social insurance premiums and taxes, a chronically high level of out-of-pocket payments, and by an insignificant level of private insurance premiums.

An analysis of the healthcare expenditure data also shows that Turkey's healthcare system stands apart from those of mature welfare states with regard to the level and structure of healthcare expenditure. Most significantly, findings in the previous section suggest the family has been a key actor

⁸⁶ Exchange rates from January 1, 2011.

in healthcare financing and provision, and that this role has been strengthened and reproduced by governmental policies.

Although healthcare expenditure remains comparatively low and specific traits of the healthcare system persist, my findings suggest a transformation in the Turkish healthcare system since the AKP came to power. Coverage of the healthcare system has reached universal levels, social insurance premiums have gained momentum as the main financing source, and the share of out-of-pocket payments has dropped substantially.

Elaborating on these findings, this section examines policy changes and shifts in the actor constellation in the financing dimension of Turkey's healthcare system. More specifically, based on the SHA 2011, I categorize and compare healthcare financing schemes that existed prior to the AKP government with those introduced under AKP rule. I examine changes in the actor constellation within the respective schemes by categorizing financing agents and financing institutions as institutions associated with the state, the market, non-governmental actors, or the family. Additionally, based on secondary literature analysis and on the findings of the historical institutional framework of this thesis, I analyze the political principles and policy goals that underpin these schemes. I show that while the different hegemonic political paradigms of 20th century Turkey have shaped the respective financing schemes, a mature welfare state that secures its citizens on the basis of social rights had not evolved until the rise of the AKP and the subsequent HTP reforms. In this chapter, I show that there has been a paradigm shift toward universal healthcare over the last decade.

5.2.1 Healthcare financing prior to the HTP

Prior to the HTP, a multitude of healthcare financing schemes coexisted. These schemes differed substantially with regard to modes of participation, fund raising, and pooling mechanisms, as well as the benefits package they provided. In the following, I analyze how the interdependency of various institutions and political ideas in these schemes resulted in different arrangements for healthcare financing.

According to the SHA 2011, government schemes are characterized by an automatic mode of participation, either for all citizens or for a specific group defined by law. Benefit entitlement is noncontributory and universal. The basic method for fundraising is budget revenues, and funds may be pooled on the national, subnational, or program level (OECD et al. 2011, 163).

As I have shown in Chapter 2, prior to the 1960s, the Turkish state's responsibility in healthcare financing was limited to the financing and provision of preventive care and disease control. This changed in 1961 with the Socialization of Health Services Law, which created a tax-funded government

scheme run by the central government that at least in theory, gave access to preventive and outpatient curative care to all citizens based on universal and noncontributory entitlement.

The establishment of a government preventive and curative outpatient care scheme has to be viewed in the context of the political developments of the 1960s and 1970s, which were ideologically framed by the paradigm of national developmentalism. Economic growth and social justice were perceived as integral parts of Turkey's democratic development. Inspired by the developments in the Western and Northern European welfare states, the developmentalist ideology was complemented by the idea of health as a fundamental human right. In this logic, health was a citizen's right and healthcare provision became the state's responsibility to the individual.

However, the advent of a new political ideology did not lead to a paradigm shift in healthcare policy. The weak governments of the 1960s and 1970s lacked the capacity to fully implement the reforms. Furthermore, the rise of new political coalitions in the post-1980s and the advent of the liberal conservative paradigm gave way to a new emphasis on insurance and household schemes.

In consequence, primary healthcare facilities across Turkey were understaffed, lacked basic funding, and were mostly used by the rural population and urban poor. In the early 2000s, some 40 percent of the patients treated in these facilities were not covered by health insurance (World Bank 2003b, 56). Furthermore, gaps in the distribution of facilities and healthcare professionals resulted in significant inequalities in access to primary healthcare across Turkey. Most people in urban areas who were covered by social insurance schemes preferred to visit the outpatient departments of hospitals or private practices to receive outpatient curative care (OECD and World Bank 2008, 35).

The scheme's key financing agent and institution was the MoH. In the early 2000's, the vast majority of the ministry's revenues came from the general budget allocated by the Ministry of Finance (*Maliye Bakanlığı*), hereafter referred to as MoF. The scheme's budget was determined on an annual basis and the MoH was accountable to the MoF. Funds were distributed by the MoH Provincial Health Directorates to the individual facilities. However, 90 percent of the ministry's budget for the scheme was spent on personnel costs and most healthcare facilities faced severe financial constraints (World Bank 2003a, 12). Hence, the mixture of revenues was diversified. In addition to taxes, so-called special funds financed by excise duties on consumer goods, such as alcohol and cigarettes, contributed to the revenues of the scheme. After legal changes in 2001, provinces were given permission to establish revolving funds for preventive and outpatient curative care facilities. These funds were backed by copayments from the social insurance institutions. Both special funds and revolving funds were managed by the scheme's key financing agent, the MoH and its Provincial Health Directorates (World Bank 2003b, 55).

However, it was common practice to impose informal user charges in outpatient curative care facilities even though services were supposed to be free-of-charge, meaning that households were effectively

cofinancing the scheme. Some facilities even set up operating funds, which were backed by copayments from patients and contributions from the local business community. These funds were pooled and managed by non-profit foundations set up by individual or multiple facilities (Ibid., 55).

Households were also expected to fully finance medical goods, which were provided by the respective facility (Ibid., 55). Accordingly, households not only functioned as financing institutions but also as complementary financing agents of the scheme as the provision of medical goods depended entirely on the household's willingness and capacity to pay.

In sum, through the establishment of a government preventive and curative outpatient care scheme the state emerged as a key actor in healthcare financing in Turkey. As a significant share of the population was not covered by health insurance, the scheme allowed large parts of society to access preventive and curative outpatient care. However, due to only partial implementation of the scheme and significant underfunding, mostly rural and underprivileged segments of society benefited from the scheme in practice.

In order to increase revenues, government policies integrated non-governmental institutions into financing the scheme. Most significantly, households functioned as financing institutions and complementary financing agents, which violated the principles of noncontributory entitlement and universal access to healthcare.

Accordingly, we can observe a shift in the policy goals underpinning the scheme, which had been established under the premise of creating equal access to healthcare for all citizens. However, by the beginning of the 2000s, its primary aim was to provide rudimentary outpatient curative care to vulnerable groups. Furthermore, some of the related policies, such as the exclusion of medical goods from the benefits package, were based on the principle that an individual's family is responsible for his or her healthcare.

A second government scheme, the Green Card scheme, was established with the explicit goal of covering the poor, who up to this point accessed inpatient care primarily through household schemes.⁸⁷ Introduced in 1992 as part of the new Law Concerning State Coverage of Treatment Expenses of Citizens Who Lack the Ability to Pay by Issuing a Green Card (*Ödeme Gücü Olmayan Vatandaşları Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun*) the scheme remained in force until 2012 (Erus et al. 2015, 100).

The establishment of the scheme has to be viewed in the context of the massive influx of rural migrants to Turkish cities throughout the 1980s, which I have discussed in Chapter 2.5. This rapid urbanization resulted in the formation of a new class of urban poor, who worked predominantly in the

⁸⁷ Before the establishment of the Green Card scheme, poor citizens could apply to the Fund for the Encouragement of Social Cooperation and Solidarity to receive funding for inpatient services. Until reforms to the Green Card scheme in 2002 and 2005, Green Card holders still had to apply for a reimbursement of the costs of outpatient care and pharmaceuticals (Günel 2008, 434).

informal labor market without access to social insurance. Accordingly, the main goal of the policies implemented within the framework of the Green Card scheme was to provide basic medical care to vulnerable groups in society. According to the new law, entitlement was limited to poor, uninsured citizens and was means-tested. An individual could apply for inclusion in the scheme if the monthly per head income of his or her household was below one-third of the net minimum wage. Once granted, Green Cards were issued to all household members up to third-degree relatives (Articles 1 to 4).⁸⁸

The Green Card scheme was financed predominantly through general taxes, with the MoF allocating funds to the MoH (World Bank 2003b, 141). Providers were reimbursed for their services directly by the MoH, making it the main financing agent of the scheme (Article 9).

Until 2002, Article 3 of the respective law entitled Green Card holders to only a rudimentary benefits package, which included inpatient treatment costs in MoH facilities and, after referral, in university hospitals. Medical goods were not included in the scheme's benefit package and had to be financed out-of-pocket. Thus, households were complementary financing agents of the scheme. In addition, households were expected to contribute to the scheme through informal out-of-pocket payments charged by providers (Tatar et al. 2007, 1036). It can be assumed that, in addition to the rudimentary benefit catalogue, the high levels of out-of-pocket payments lessened the appeal of the scheme. According to the Turkey National Household Health Expenditure Survey 2002-03, only 8.6 percent of the population were covered by the scheme (OECD and World Bank 2008, 30).

In sum, the Green Card scheme was a remarkable development in Turkish social policy. Based on the primary goal to provide basic medical care to vulnerable groups, the state formulated concrete criteria to define poverty for the first time (Ağartan 2008, 260). Policy makers acknowledged the dramatic increase in urban poverty and assumed responsibility for the healthcare of the most vulnerable segments of society.

At the same time, the exclusion of medical goods from the benefits package, suggests that the scheme was underpinned by the principle that the family shares responsibility for the healthcare of its individual members. Furthermore, the assessment of households as collectives, the entitlement of kin, and cohabitation as a criterion for entitlement, strengthened and reproduced the social role of the family. Accordingly, it is important to note that complementary to its primary goal, the scheme aimed to strengthen the family's capacity to finance the healthcare of its individual members.

A second category of health financing schemes outlined by the SHA 2011 is government employee schemes. In these schemes, governments either provide specific healthcare programs for employees or buy them private health insurance (OECD et al. 2011, 163).

⁸⁸ See also: Aran and Hentschel 2012; Erus et al. 2015; Menon et al. 2013.

As I have briefly discussed in Chapter 2, healthcare for active and passive civil servants and their dependents was organized by two separate government employee schemes. These schemes evolved as part of a path-dependent process, which can be traced back to the late Ottoman Empire. Policies were aimed at compensating individuals for social risks related to sickness based on their occupational status. Civil servants were granted privileged access to medical care and other social services in order to integrate them into the nation-building process. Accordingly, although the government employee schemes were established in the 1960s and 1970s when the new paradigm of national developmentalism had led to a partial redefinition of the state's role in healthcare, they ended up reinforcing Turkey's two-tier healthcare system and the social hierarchy among different occupational groups.

Active civil servants and their dependents were covered by a government employee scheme which was established as part of the Civil Servants Law (*Devlet Memurları Yasası*) of 1965 (Articles 188 and 209). According to the Turkey National Household Health Expenditure Survey 2002-03, 5.1 percent of the population was covered by the scheme (OECD and World Bank 2008, 30). The main financing agent of the scheme was the MoF, which allocated funds from the central state budget to the institution where the respective civil servant was employed. Providers of healthcare directly billed these institutions after treatment (World Bank 2003b, 140).

The benefits catalog of the scheme was determined by the MoF and was comparatively generous. The scheme covered the costs of outpatient and inpatient care, as well as the costs of pharmaceuticals, adjuvants, dental care, and travel expenses, which were predominantly financed from the central budget. Depending on the patient's civil service rank, the scheme provided access, not only to public, but also to private providers of healthcare and even treatment abroad. However, most secondary care services were purchased from MoH, SSK, and university hospitals (*Ibid.*, 60).

Copayment for medical goods amounted to 20 percent, while households financed informal copayments to providers. Accordingly, households functioned as financing institutions of the scheme.

Retired civil servants and their dependents were covered by the *Emekli Sandığı* (Retirement Fund). While the fund was founded in 1949 as part of the Law on the Retirement Fund of the Turkish Republic (*Türkiye Cumhuriyeti Emekli Sandığı Kanunu*), it did not cover healthcare benefits until 1971. While it was established as a pension insurance agency which collected premiums from active civil servants and the public institutions that employed them, the contributions exclusively financed pension schemes, such as old-age and survivors pensions. In contrast, the *Emekli Sandığı's* health insurance section was exclusively funded by subsidies from the general budget (Savaş et al. 2002, 40). Households cofinanced 10 percent of the cost of medical goods as well as informal copayments to providers and thus functioned as financing institutions of the scheme (Article 7). In 2002 and 2003, 5.1 percent of the population was covered by the scheme (OECD and World Bank 2008, 30).

The third category of health financing schemes is social health insurance schemes, which are defined as “a financing arrangement that ensures access to healthcare based on a payment of a non-risk-related contribution by or on behalf of the eligible person. The social health insurance scheme is established by a specific public law, defining, among others, the eligibility, benefit package, and rules for the contribution payment” (OECD et al. 2011, 169).

Prior to the HTP there were two large social insurance schemes. In 1964, the SSK, which was established as part of the Social Insurance Law (*Sosyal Sigortalar Kanunu*), began covering active and retired private sector employees, as well as blue-collar public sector employees and their dependents.⁸⁹ As I have shown in Chapter 2, similar to the government employee schemes, the social insurance scheme has to be understood as the institutional outcome of a path-dependent process in which the state integrated certain occupational groups into the project of state-building by granting them privileged access to medical services.

Accordingly, policies related to the scheme were aimed at creating the institutional conditions that allow certain occupational groups to be compensated for social risks related to sickness. The scheme was predominantly financed by premiums but was also state-subsidized as it became increasingly loss-making (World Bank 2003b, 137-39).

According to Wendt et al., social insurance premiums constitute a form of societal-based funding. They cannot be considered a form of state funding, as the government has no direct access to social insurance revenues. At the same time, health insurance premiums differ from other forms of private sector funding. Social insurance agencies are non-profit organizations, coverage is mandatory, and redistribution occurs ex ante. Accordingly, the share of social insurance premiums and the coverage of social insurance schemes indicate the relevance of non-governmental actors in the financing dimension (Wendt et al. 2009, 78). The SSK is, therefore, considered a non-governmental actor.

The collection and pooling of funds as well as the administration of the scheme were carried out by the SSK as the key financing agent. In the early 2000s, active insurants contributed 5 percent of their salaries while employers added a further 6 percent (World Bank 2003b, 138). According to the Social Insurance Law, insurants were entitled to services after making contributions for 60 days. Households functioned as complementary financing institutions and contributed in the form of formal copayments for medical goods, which amounted to 20 percent for active and 10 percent for retired insurants. Households also made informal copayments (Articles 32 to 42). With coverage of 33.5 percent of the population in 2002 and 2003, the SSK was the largest insurance scheme, suggesting an already strong

⁸⁹ The first major social insurance scheme for workers was the Workers Insurance Institution (*İşçi Sigortalar Kurumu*) founded in 1946. While its benefit catalogue only covered the treatment of occupational diseases and work accidents, coverage was extended to general health issues in 1951.

role for non-governmental actors in healthcare financing prior to the AKP reforms (OECD and World Bank 2008, 30).

Merchants, artisans, and the self-employed were insured through a second social health insurance scheme administered by the *Bağ-Kur*. As with the SSK, I categorize the *Bağ-Kur* as a non-governmental actor. Established as a pension fund in 1971 through the Law on the Social Insurance Institution for Tradesmen and Craftsmen and Other Self-Employed Workers (*Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu Kanunu*), the scheme began financing the healthcare of insureds in 1987. Self-employed agriculture workers were included in the scheme from 1999 onwards.

The related policies aimed at creating the institutional conditions that allow respective occupational groups to be compensated for social risks related to sickness. However, compared to government employees and insureds with the SSK, *Bağ-Kur* insureds were disadvantaged, most significantly because they had to contribute to the scheme for eight months before being entitled to benefits. Furthermore, those with premium debt were denied access to medical care (World Bank 2003b, 139).

In the early 2000s, the *Bağ-Kur* was predominantly financed through members' premiums, which amounted to 12 percent of the insured's notional income. In addition, the state contributed to the loss-making scheme through subsidies (Savaş et al. 2002, 45). Copayments for drugs amounted to 20 percent for active and 10 percent for passive insureds. Households that also contributed to the scheme in the form of informal out-of-pocket payments served as financing institutions of the scheme. According to the Turkey National Household Health Expenditure Survey 2002-2003, 11.7 percent of the population was covered by the scheme (OECD and World Bank 2008, 30). However, in the early 2000s, only 3.3 million members actively contributed to the scheme (Savaş et al. 2002, 45).

A fourth category of financing schemes that existed prior to the HTP reforms was the voluntary health insurance schemes. These schemes are marked by several characteristics, namely voluntary participation which is at the discretion of the private health insurance company; benefit entitlement which is based on the purchase of an individual insurance policy; non-income related premiums as the main method for fund-raising; and the pooling of funds on the level of individual schemes (OECD et al. 2011, 163). Accordingly, related policies are commonly based on the premise that an individual's access to care should be based on his or her market position.

Voluntary health insurance schemes existed prior to the HTP but were supplementary, as Turkish social security law did not provide an opt-out option from the government employee and social insurance schemes. Funds were pooled on the level of the insurance companies, which functioned as the key financing agent of the individual schemes. According to Article 9 of the Law on Insurance Regulation (*Sigorta Murakabe Kanunu*) from 1959, premiums, benefits packages, coverage regulations, including coverage of dependents, were at the discretion of the health insurance company and varied across different schemes. Insureds in voluntary schemes did not receive tax subsidies and there were

no regulations defining legal standards or minimum benefits packages. Insurance companies usually contracted with individual healthcare providers and reimbursed them for services directly. Some schemes also reimbursed insureds when they visited non-contracted providers. The level of copayments depended on individual insurance plans. Hence, in some schemes, households functioned as financing institution and complementary financing agents (Savaş et al. 2002, 52).

Prior to the HTP, voluntary health insurance schemes played a negligible role in healthcare financing. In 1991, the number of Turks covered by voluntary health insurance schemes was as low as 25,000 (Ibid., 53). At the beginning of the 1990's, Turkey experienced a boom in private, profit-oriented healthcare facilities. As the treatment in these facilities was not covered by social insurance schemes, private health insurance gained popularity.

However, weak regulation of the private insurance sector and ever-rising premiums limited the appeal of voluntary health insurance schemes. In 2000, 620,000 insureds, less than one percent of the population, were covered by voluntary health insurance schemes (Ibid., 53). An estimated 3.7 percent of healthcare expenditure was made by private insurance schemes, and by the end of 2003, 36 health insurance companies covered less than one percent of the population (Tatar et al. 2011, 75). Accordingly, prior to the HTP, the market's role in healthcare financing can be considered marginal and I argue that commodification of healthcare financing was not a stated goal for policy makers.

The SHA 2011 defines household out-of-pocket expenditures as a financing scheme. Household schemes differ from other schemes as no third-party financing institutions contribute to their revenues. Payments are made directly from the patient's household to the care providers and the individual household is the sole financing agent and financing institution. It is, therefore, necessary to distinguish between a household as financing institution and a household as financing scheme.

Households, as an institutional sector, play several roles in the health system: as beneficiaries, as providers of sources to third-party financing schemes (by paying taxes and or insurance contributions and or insurance premiums), as informal providers of care, and last but not least, as the financing agent for OOP [out-of-pocket payments] (OECD et al. 2011, 177).

Household schemes are characterized by a voluntary mode of participation. While funds are pooled by the household and the purchase of healthcare depends on the member's ability or willingness to pay, the cost of services may be determined by providers or by other schemes, such as government or social insurance schemes (Ibid. 178-79).

Prior to the HTP, out-of-pocket payments played a significant role in healthcare financing. Particularly striking was the large share of the population that relied exclusively on household schemes in order to access healthcare. According to OECD data, 28.4 percent of the population in 2003 was not covered by any of the government employment schemes, social insurance schemes or the Green Card scheme (OECD Health Statistics 2016). According to the 2002/03 Household Budget Survey, the figure was

even higher at 32.8 percent (OECD and World Bank 2008, 30). The government preventive and curative outpatient care scheme provided, at least in theory, access to free care for all residents in Turkey. However, limited access to providers left citizens, especially those without health insurance, no choice but to pay out-of-pocket to be able to access outpatient curative care at private or public facilities. Furthermore, the uninsured relied exclusively on household schemes to be able to access inpatient care. It needs to be highlighted, that while the related policies were supported by the premise that the patient's family is responsible for his or her healthcare, the state did little to strengthen the capacity of households to finance healthcare. Accordingly, the exclusionary policies that were in place prior to the HTP were not based on the principle of subsidiarity. Rather, the state left responsibility of a significant share of its citizens' healthcare entirely to the family.

Not surprisingly, access to formal healthcare schemes determines to a significant degree whether a patient seeks professional assistance when sick. Recent studies on Turkey have found that 44.1 percent of those not covered by any formal scheme do not consult a doctor when sick and 97.2 percent give state healthcare costs as the primary reason for not seeking care (Erus et al. 2015, 103). Furthermore, my analysis of data on healthcare expenditure suggests that prior to HTP reforms, certain healthcare functions, such as long-term care, were exclusively financed through household schemes. Additionally, out-of-pocket payments were an integral part of the government and social insurance schemes described above. All major schemes resorted to households as financing institutions.

The examples exemplify the immaturity of the Turkish welfare state and emphasize that public policies were underpinned by the premise that the family was responsible for financing the healthcare of its individual members. While the state protected only specific occupational groups from the social risks related to sickness, it did little to strengthen the family's capacities to fulfill its attributive role.

Separately, informal payments played a significant role in financing the existing healthcare schemes. Prior to the HTP, patients often made informal out-of-pocket payments although they were legally entitled to free services. A study conducted by Tatar et al. in 2002, found that 25 percent of out-of-pocket payments in Turkey were informal. Informal payments comprised donations to operating funds established by MoH preventive and outpatient curative care institutions; direct payments to physician services in public settings; direct payments to other health professionals; pharmaceuticals in inpatient settings; and gift and in-kind contributions to healthcare professionals (Tatar et al. 2007, 1033).

Two-thirds of out-of-pocket payments in 2002 were made in the private sector and one-third in the public sector. Thirty-eight percent of out-of-pocket payments in the public sector were made informally, with the majority of these going on medical goods in inpatient settings. However, 23.5 percent of informal out-of-pocket payments in the public sector were made to gain access to surgical services, and 11.1 percent were donations to healthcare facilities, such as the revolving funds of MoH

outpatient facilities and hospitals. In the private sector approximately 22 percent of out-of-pocket payments were informal, with 99 percent of these going on medical services. Accordingly, most informal payments were for services, rather than gratuities to healthcare professionals. Payments made by those in government employee schemes or social insurance schemes were primarily for medical services. Informal payments by Green Card holders predominantly financed surgical services (Ibid., 1033-37).

These findings support my claim that prior to the HTP, it was common practice among doctors in public and in private settings to charge informal out-of-pocket payments. Additionally, many patients made payments to physicians during their working hours in private settings, while the actual services were provided in public settings. In Chapter 7, I show how public policies that were based on the premise of the family being responsible for financing the healthcare of its individual members, supported these practices.

As discussed in the previous section, high out-of-pocket payments significantly contributed to inequities in healthcare, particularly in terms of restricting vulnerable groups from accessing services. Only 55 percent of the uninsured and 75 percent of Green Card holders sought medical care when severely sick, as opposed to 87 percent of civil servants insured with the *Emekli Sandığı* and 93 percent of the members of voluntary health insurance schemes (World Bank and TurkStat 2005, 78).

The findings reveal the extraordinary importance of households in healthcare financing prior to the HTP. Around one-third of the population relied fully on household schemes in order to access inpatient care. Additionally, all existing schemes resorted to household revenues in the form of formal or informal out-of-pocket payments.

As I have discussed in Chapter 4.2, Wendt et al. argue that high out-of-pocket payments indicate a strong role of the family in healthcare financing. However, we still know very little about financial flows within households and families in Turkey. Therefore, the generalized claim that high out-of-pocket payments and the significant role of household schemes in healthcare financing prove the predominant role of the family in healthcare system needs to be treated with caution. However, in the Turkish context it can be considered valid.

Households in general may be composed of members who do not belong to one family; however, Turks almost exclusively cohabit with family members. In 2000, 75.8 percent of households in Istanbul comprised only members of the nuclear family. Only 7.6 percent of households were composed of extended families. The average size of Istanbul households was 3.6, compared to 4.5 for Turkey as a whole. Only a nominal 2.1 percent of households were comprised of members who were not related (Duben 2013, 23).

While household membership does not necessarily require family membership, financial assistance, as well as care, may also be provided by kin or family members who do not cohabit in the same

household. When examining other fields of the Turkish welfare system, such as housing, children, and elderly care, a number of studies highlight the importance of inter-generational as well as family assistance across households.⁹⁰

Generational ties between parents and their (married) children continue to be very strong, even in cases of separate residence - a tribute to continuing final devotion. Intergenerational ties are often solidified by nominally separate but functionally combined residence. Sharing separate flats in a common building is very desirable and frequently chosen solution, and the pattern is set as new households are formed by marriage, and parents who can afford to do so provide often furnished living quarters for newly-wed offspring, as is also the case in many southern European countries. Such patterns extend across the social classes in Turkey and, until recently, could be found even in squatter areas where, dependent upon family social capital and wealth, some degree of parental provision of housing and pooling of resources was the norm and a key element of urban integration (Ibid., 41-42).

Although further research, in particular ethnographic research, is necessary to analyze how nuclear families and kin pool financial resources across households and generations, I maintain that the family has been a key actor in healthcare financing prior to the HTP. A third of the population had access to inpatient care and medical goods exclusively through household schemes, while important healthcare functions, such as long-term care, were entirely financed by households.

The state likewise played an important role in healthcare financing. The financing agents and main financing institutions of the government schemes were state institutions. At the same time, the social insurance schemes were co-financed by the central budget. However, my analysis shows that the government only reluctantly took responsibility for the healthcare of its citizens. While some policies protected vulnerable groups from the social risks related to sickness, the overall immaturity of the Turkish welfare state further contributed to the importance of the family in healthcare financing. I have furthermore shown that policy makers perceived the family as a revenue source. All schemes administered by the state or non-governmental actors resorted to households as financing institutions. Additionally, my findings suggest that the family's role was reproduced and strengthened by governmental policies that to varying degrees were underpinned by the premise that the family is responsible for the healthcare of its individual members. However, at the same time, the state did little to strengthen the capacities of the family to fulfill this role. I examine this claim further in Chapter 7.

As the majority of the population was covered by SSK and *Bağ-Kur* social insurance schemes, which were predominantly financed by insurance premiums, I conclude that non-governmental actors were likewise important in healthcare financing. The policies related to the schemes were aimed at creating the institutional conditions that allowed certain occupational groups to be compensated for the risks and costs related to sickness. It needs to be emphasized that variations in the benefit catalogues

⁹⁰ See: Duben 2013; Buğra 1998; Kalaycıoğlu and Rittersberger-Tılıç 2000; Kalaycıoğlu 2006; Keyder and Buğra 2006; Grütjen 2008.

across the schemes further contributed to inequities in healthcare and consolidated social hierarchies across societal groups.

In contrast, market actors only played a marginal role in healthcare financing. Likewise, the goal of commodifying healthcare financing was played a minor role in policy making. In the following, I examine how the actor constellation in the financing dimension of healthcare and the goals which underpin the related policies have changed since the AKP came to power.

5.2.2 Healthcare financing since the implementation of the HTP

The findings of the first part of this thesis show that the reforms implemented by the AKP government have led to significant changes in healthcare financing in Turkey. In the following, I analyze the changes in healthcare policy goals and the actor constellation within the existing healthcare financing schemes. The HTP gave way to a comprehensive restructuring in the financing of preventive and outpatient curative care. A pilot family medicine program under the 2004 Family Medicine Law (*Aile Hekimliği Kanunu*), was gradually rolled out across the country, introducing a new care provider structure. Starting in the province of Düzce in 2005, the program, which aimed to replace the existing network of state-run preventive and outpatient curative care facilities, was extended to all of Turkey's 81 provinces by the end of 2010. Since 2011, when the program was declared a permanent government initiative, preventive and outpatient curative care has been financed by a government scheme in which MoH-contracted physicians provide care in private practices to a specific list of citizens (Kringos et al. 2011; World Bank 2013). Funds continue to be pooled at the central level, and although doctors have lost their civil servant status, salaries and operational costs are directly financed from the MoH budget (Article 3). Similar to previous regulations, the budgets of individual health facilities are determined and distributed on the provincial level. Hence, the key financing agent is the MoH and the scheme is no longer cofinanced by revenues from local businesses or social insurance agencies. Furthermore, medical goods, which were previously financed entirely by households, are now covered by the scheme (Kringos et al. 2011, 12). Accordingly, the family has lost its role as a complementary financing agent.

Recent research shows that the state still falls short of its promise of universal access to free preventive and outpatient curative care. Many healthcare providers still demand out-of-pocket payments for services and medical goods that by law should be free of charge for every Turkish citizen. A study conducted in the provinces of Bolu and Eskişehir found that 50 percent of patients were obliged to make copayments for prescribed medicines and injections. Twelve percent reported having to make informal out-of-pocket payments for home visits (Ibid., 12).

However, a number of academic studies and international organizations have praised the positive impact the HTP reforms have had on access to preventive and curative outpatient care (Barış et al. 2011; Menon et al. 2013; World Bank 2013). A study conducted by the World Bank showed that access to primary care and service utilization has significantly improved since the introduction of family medicine. The number of primary care consultations across the country rose from 1.9 visits per capita in 2005 to 2.8 visits per capita in 2009. In 2009, the number of consultations in provinces that had introduced family medicine was 2.9 per capita, while it was 2.1 per capita in provinces that had not yet transformed its primary care system (Ibid., 19).

Similarly, access to a range of services, especially immunization and prenatal care, has improved significantly over the last decade. Between 2003 and 2010, the number of antenatal care visits increased from 3.8 visits per capita to 4.6 visits per capita (Ibid., 19). Over the same period, the infant mortality rate fell from 28.5 to 10.1 deaths per 1000 live births and the maternal mortality rate fell from 61 to 16.4 deaths per 100,000 live births. Simultaneously, Turkey managed to significantly improve its immunization rates (Ibid., viii). Furthermore, a number of services that were often financed through out-of-pocket payments, such as vaccinations, prenatal examinations, and infant follow-up examinations, have become part of the scheme's benefits catalog (Menon et al. 2013, 5).

However, more in-depth research on the outcomes of the HTP reforms is needed to determine the level of causality between the healthcare policies and the quality and utilization of services. Existing data, therefore, should be analyzed with caution. For example, MoH documents suggest causality between the introduction of family medicine and higher immunization rates, however, the most significant increase in vaccination rates occurred in the years prior to the implementation of family medicine (World Bank 2013, 23).

In sum, improvements in access and utilization of services financed by the scheme indicate a stronger role of the state and a decline in importance of non-governmental actors and the family. Furthermore, my findings suggest a paradigm shift in the policy goals that underpin the scheme. In contrast to previous decades, the policies implemented by the AKP no longer aim to provide services to vulnerable groups. Policies are, instead, underpinned by the goal that all citizens should have equal access to preventive and curative outpatient care. I elaborate further on this claim in Chapter 7.

Aside from the restructuring of preventive and outpatient curative care, other main healthcare reforms of the last decade have been the establishment of a single administrative body responsible for the management of all healthcare financing schemes, the SGK, and the introduction of General Health Insurance (*Genel Sağlık Sigortası*).

In 2006, the Turkish parliament passed the Social Security Institution Law (*Sosyal Güvenlik Kurumu Kanunu*), under which the SSK, *Bağ-Kur*, and *Emekli Sandığı* schemes were absorbed into the newly established SGK. In 2010, the Active Civil Servant Scheme was also absorbed into the SGK, followed by

the Green Card scheme in 2011. As a result, the SGK has become the key financing agent which administers and operates the major schemes of the Turkish healthcare system. The MoH was stripped of its role as the purchaser of healthcare services for Green Card holders. Today, the ministry's role in healthcare financing is limited to paying staff salaries and covering running costs of public healthcare facilities (OECD 2014, 41).

The establishment of the SGK was complemented by the introduction of General Health Insurance as part of the Social Security and General Health Insurance Law (*Sosyal Güvenlik ve Genel Sağlık Sigortası Kanunu*), which in theory, entitles all Turkish citizens and registered foreigners to healthcare. Only conscripts, diplomats, prisoners, and foreigners covered by healthcare schemes in their home country, as well as short-term visitors and illegal immigrants, have currently no access to the existing public schemes (Article 60).

Furthermore, the approximately three million Syrian refugees currently in Turkey are not covered by any of the schemes. Instead, registered refugees can, since 2013, access healthcare under a separate government scheme administered by the MoH as part of the Law on Foreigners and International Protection (*Yabancılar ve Uluslararası Koruma Kanunu*).⁹¹

The reform that established the SGK came into effect on 1 October 2008. Insurants and their dependents that entered the social insurance system before this date are technically still enrolled according to the old entitlement criteria and benefit catalogues. However, in the years prior to the reform, the AKP government passed a series of measures aimed at harmonizing the benefit catalogues of the existing schemes. In 2006, the Budget Implementation Guide (*Bütçe Uygulama Talimatları*) was declared binding for all schemes. Published by the MoF, the guide had previously determined the benefits packages of all the government employee schemes. Since 2007, a single benefits package for all schemes, the Health Implementation Guide (*Sağlık Uygulama Tebliği*), has been published by the SGK (Tatar et al. 2011, 49-53).

Each SGK scheme is financed by different financing institutions, however, revenues are collected and pooled at the central level. Only the premiums of insurants who entered the social security system prior to October 2008 are pooled separately. The government contributes to the revenues of the SGK by financing a series of government schemes. Furthermore, the state subsidizes the SGK by compensating the agency's deficits from the central budget and by transferring funds amounting to 25 percent of the collected premiums in monthly installments (Ibid., 63).

The SGK purchases services from public and private providers. The SGK allocates an annual budget to the MoH to reimburse services provided at MoH hospitals. Since 2004, social security institutions have been allowed to sign contracts with private hospitals (Erus and Aktakke 2012, 339). According to the

⁹¹ See also the Temporary Protection Regulation (*Geçici Koruma Yönetmeliği*) from 2014 and Kutlu 2015.

Regulation on Private Hospitals (*Özel Hastaneler Yönetmeliği*), which was passed in 2002, the SGK purchases services from contracted private providers and individual services are purchased on a fee-for-service basis.

While transfers from the central budget and social insurance premiums account for the majority of SGK revenues, households contribute in the form of copayments. The Social Security and General Health Insurance Law has harmonized the regulations for all schemes, which I outline in detail below. As of 2015, copayments amount to 2 Turkish lira for outpatient and dental care examinations provided by public providers other than family physicians. Copayments for pharmaceuticals, as well as orthoses and prostheses, amount to between 10 and 20 percent of the item's total cost (Article 68).

Private hospitals that have contracted with the SGK have the right to charge patient copayments for services. Private institutions, which have not signed a contract with the SGK, are free to set their own fees-for-services. However, according to Article 67 of the Social Security and General Health Insurance Law, they are obliged to provide emergency care free of charge. I discuss the regulation of private healthcare providers further in Chapter 7.

According to law, the following groups have to contribute to compulsory health insurance: (i) active insurants, such as blue and white collar workers, civil servants and the self-employed; (ii) optional insurance holders; (iii) unemployed citizens who receive benefits from the Turkish Employment Agency (*Türkiye İş Kurumu, İş-Kur*); and (iv) foreigners residing in Turkey who are not covered by a health plan abroad, as well as all foreign students (Article 61).

The law also defines those groups that are covered by the General Health Insurance but are exempt from premiums: (i) the poor, defined as individuals with a domestic per capita income lower than one third of the minimum wage; (ii) refugees and stateless individuals; and (iii) pension holders (*Ibid.*).

Additionally, the law lists those groups that are exempt from payment for health services:

(i) individuals under the age of 18 years; (ii) individuals who are medically in need of another person; (iii) individuals who need assistance due to traffic accidents, work accidents, occupational disease, as well as emergency cases; and (iv) individuals who need inpatient or outpatient maternity care. Furthermore, healthcare, including preventive care, during disasters or war, and during strikes and lockouts are provided free of charge.

While the law promises the same access to healthcare for all citizens, in reality, the SGK administers a multitude of different financing schemes, which differ significantly with regard to entitlement criteria, types of revenue, and financing agents. In the following I outline in detail the impact of the HTP on the existing healthcare schemes.

A key focus of the HTP healthcare policies was further integration of the poor into compulsory General Health Insurance. The government scheme Green Card, which granted the poor access to free

secondary care from 1992 onwards, was gradually reformed and in 2012, replaced entirely by a government scheme administered by the SGK.

Prior to this, a series of policies throughout the 2000s had focused on expanding the scheme's benefit package. Reforms in 2002, 2004, and 2005 gradually granted Green Card holders access to outpatient treatment in public hospitals and outpatient prescription drugs. In 2006, the pharmaceutical positive lists of the Green Card scheme and the social insurance schemes were synchronized. Legal changes in 2007 and 2008 further harmonized benefit packages of the various schemes.⁹²

As benefit catalogues standardized health expenditure for Green Card holders gradually came in line with social insurance schemes. In 2004, the average spent on health per Green Card holder was 176 Turkish lira, compared to 323 Turkish lira for SSK insurants. In 2009, expenditure per person was almost equal at 570.70 Turkish lira for Green Card holders and 590.30 Turkish lira for SGK insurants (Atun et al. 2013).

Means-testing under the Green Card scheme posed significant problems for authorities and led to social security fraud, mainly due to difficulties in verifying income and conducting collective household assessments, as well as the fact entitlement was often extended to kin. A study based on 2006 data found that one-fifth of Green Card holders did not fulfill entitlement criteria. At the same time, one-third of the poorest 30 percent of the Turkish population were not covered by the scheme, suggesting significant deficiencies in the entitlement procedures (Gürsel et al. 2009, 3-4).

Based on household data from 2007, Erus et al. found that 31.4 percent of Green Card holders did not consult a doctor when sick. Almost 90 percent of respondents in the data gave costs as the primary reason for not consulting a doctor. At the same time, 43.6 percent of households did not apply to the scheme although they fulfilled the entitlement criteria. While the young and those fit to work were particularly reluctant to register, a significant share of individuals without access to the scheme belonged to high-risk groups. Among those who had not applied to the scheme despite fulfilling entitlement criteria, 34.2 percent had a chronic illness and 32 percent were either elderly or disabled (Erus et al. 2015, 102). These findings suggest that despite the reforms, households continued to function as financing institutions and complementary financing agents of the Green Card scheme.

In January 2012, the Green Card scheme was abolished and replaced by a government scheme administered by the SGK, which also took over the role as key financing agent from the MoH. According to official data, the new scheme covered approximately 9.5 percent of the population in 2014 (SGK online). It is financed through a global budget, which is pooled by the SGK and allocated from the central budget on an annual basis. In case of overspending, additional funds are transferred to the SGK from the central budget (Tatar et al. 2011, 63). According to Article 68 of the Security and

⁹² For an overview see: Atun et al. 2013; Menon et al. 2013.

General Health Insurance Law, beneficiaries are not exempt from formal copayments which amount to 20 percent for medical goods.

Access to the scheme is still means-tested but via a new method conducted by the Foundation for Social Assistance and Solidarity (*Sosyal Yardımlaşma ve Dayanışma Vakfı*) and based on national standards determined in the Social Assistance Information System (*Sosyal Yardım Bilgi Sistemi*). It can be assumed that the modernization of the registration process has made social security fraud more difficult (Yılmaz 2013, 69). In Chapter 7, I discuss further how the new entitlement policy affects the role of households in healthcare financing.

In sum, the reform of entitlement criteria and the benefits catalog of the Green Card replacement scheme has significantly increased health equity in the Turkish healthcare system. The new scheme currently finances the same benefits as the other schemes administered by the SGK. Coverage of the scheme has been extended, resulting in a reduction in the share of the population that relies on household schemes to access inpatient care. While the scheme continues to be financed by taxes, administration has been transferred from the MoH to the SGK. Accordingly, the role of the financing agent has shifted from the state to a non-governmental actor. Households are financing institutions of the scheme as they cofinance medical goods.

The comprehensive extension of the scheme's coverage and benefits catalog suggests a paradigm shift. Prior to the HTP, the Green Card scheme aimed to create access to rudimentary services for vulnerable groups and was underpinned by the premise that the family shares responsibility in financing the healthcare of its individual members.

In contrast, the reform of the Green Card scheme has to be seen as part of a comprehensive change in healthcare policies, which aim to ensure equal access to healthcare for all citizens. Although the scheme is administered by a non-governmental actor, it is exemplary for the emergence of a mature welfare state which protects its citizens on the basis of social rights.

The Social Insurance and General Health Insurance Law also created a new compulsory social insurance scheme for citizens that do not fulfill the entitlement criteria for the government scheme for the poor. According to official data, the compulsory scheme covered 5.2 percent of the population in 2014 (SGK online).

As of January 2012, all Turks who are not registered with the SGK are obliged to take the mandatory means test organized by the Foundation for Social Assistance and Solidarity. Monthly premiums are calculated according to the household's income.⁹³ For the first half of 2015, premiums were set at 48.06 Turkish lira for households with a per capita income lower than the minimum wage; 144.18

⁹³ See the Regulation Regarding the Procedures and Principles Related to Revenue Assessment, Registration and Monitoring Processes within the Scope of General Health Insurance (*Genel Sağlık Sigortası Kapsamında Gelir Tespiti, Tescil ve İzleme Sürecine İlişkin Usul ve Esaslar Hakkında Yönetmelik*) of 2012.

Turkish lira for households with a per capita income lower than twice the minimum wage; and 288.36 Turkish lira for households with an income higher than twice the minimum wage (Ibid.). Funds are pooled centrally by the SGK (Tatar et al. 2011, 63).

When focusing on the policy goals that underpin the scheme, a mixed picture emerges. The main policy goal is to create the institutional conditions that allow for the compensation of risks and costs related to sickness. At the same time, the state subsidizes the premiums of vulnerable groups in society with the aim of creating access to healthcare for the entire population. In Chapter 7, I analyze in further detail the policies that regulate access to the scheme.

Since 2008, the government scheme for passive civil servants, previously administered by the *Emekli Sandığı*, has been administered by the SGK under the category 4-1/c. In 2010, the government scheme for active civil servants was also transferred to the SGK. The scheme is financed through an annual budget, which is transferred from the central budget to the SGK on an annual basis, and through copayments for medical goods by insureds (Ibid., 63-64). Both schemes combined covered 14.3 percent of the population in 2014 (SGK online). With the introduction of the single benefits catalog for all SGK schemes, active and retired civil servants have lost their privileged status. However, the related policies have not altered the main goal behind the scheme of creating access to healthcare services based on civil servant status.

In congruence to the government schemes, the social insurance schemes that existed prior to the HTP, the SSK and *Bağ-Kur*, were dissolved and reorganized under the umbrella of the SGK. The SGK administers a new compulsory social insurance scheme for private sector employees and blue collar workers in the public sector under category 4-1/a. The scheme is financed through premiums from employers and employees who contribute 7.5 percent and 5 percent of insureds' earnings respectively. Additionally, the state contributes a quarter of the collected healthcare contributions per month. Insureds have to contribute for a minimum of 30 days until they and their dependents are entitled to services, down from 60 days prior to the reform. The regulations for copayments described earlier are applicable. For pharmaceuticals, as well as orthoses and prostheses, they amount to between 10 and 20 percent of the item's total cost. With coverage of 50 percent of the population, the scheme was the largest scheme administered by the SGK in 2014 (Ibid.).

The SGK also administers a compulsory insurance scheme for the self-employed, artisans, merchants, and agricultural workers under the category 4-1/b. Premiums amount to 12 percent of their income. The state contributes a quarter of the collected healthcare contributions per month.

Insureds have to contribute for a minimum of 30 days before service entitlement, which they lose if premium debt exceeds 60 days. The regulations for copayments described earlier are applicable for the scheme. For pharmaceuticals, as well as orthoses and prostheses, they amount to between 10 and

20 percent of the item's total cost. According to official data, the scheme covered 18.8 percent of the population in 2014 (Ibid.).

The reforms of the HTP have not led to changes in the main policy goals behind the schemes. Both reforms aim to create the institutional conditions that allow for the compensation of specific occupational groups for risks and costs related to sickness. When focusing on the impact of the policy reforms on the actor constellation within the schemes, the institutional unification of the SSK and the *Bağ-Kur* within the SGK has not changed the fact that the schemes are administered by non-governmental actors. The state has gained importance as a financing institution and subsidizes the SGK. Households continue to contribute to the financing of the scheme in the form of copayments for medical goods. Accordingly, at least on first sight, the actor constellation in the social insurance schemes is dominated by non-governmental actors. I discuss this observation in further detail in Chapter 7 where I analyze how the state regulates the SGK.

The policy changes I have outlined have substantially increased the overall coverage of the government and social insurance schemes. According to SGK data, 83.7 percent of the Turkish population was covered by the social insurance and government employee schemes in 2014, while 14.7 percent had access to health insurance through the government scheme for the poor and the compulsory health insurance scheme (Ibid.). However, in Chapter 7 I show that the official numbers need to be treated with caution.

The relevance of voluntary health insurance schemes has marginally increased since the launch of the HTP, however, the share of coverage remains low. According to OECD data, less than one percent of the population was covered under voluntary health insurance schemes in 2003 (OECD and World Bank 2008, 30). The Turkish Insurance Association (*Türkiye Sigorta Birliği*) states that in 2013 a total of 2.8 million people were covered by voluntary health insurance schemes, corresponding to 3.5 percent of the population (2014, 30). More recently, legal groundwork has been prepared for the sale of supplementary health insurance policies (Yılmaz 2013, 66), however, the role of the market in healthcare financing in general can still be considered minimal.

As I have shown, the reforms of the HTP have significantly decreased the share of the population that depends on household schemes to access healthcare. According to official data, less than two percent of the Turkish population is not covered by the SGK schemes (OECD Health Statistics 2016). However, household data indicates that official data should be treated with caution. According to a household survey of 2009, the share of household heads without any health insurance was still 10.8 percent (Yardım et al. 2014, 181), while according to OECD data only 6 percent of the population was not covered (OECD Health Statistics 2016). Currently, the main groups that are not covered by government and social insurance schemes administered by the SGK are those who live in households with an average income higher than one third of the minimum wage but who do not pay their premiums; and

those who do not apply for the government scheme for the poor despite fulfilling the entitlement criteria.

The number of individuals who do not have access to healthcare because of premium debt is significant. According to SGK data from 2010, only 36.3 percent of active insurants who were enrolled with the social insurance scheme for the self-employed had no premium debts. Accordingly, some two million insurants and their dependents had no access to healthcare during that period (Yaşar and Uğurluoğlu 2011, 291). Furthermore, a growing number of unregistered refugees and migrants have no legal access to healthcare.

As discussed above, the schemes administered by the SGK finance a comprehensive benefits catalog that theoretically grants full access to outpatient and inpatient curative, rehabilitative, and long-term care, as well as medical goods. In practice, however, a number of services are predominantly financed through household schemes. As the analysis of expenditure data indicates, the weak institutionalization of long-term care and the underdevelopment of home care place a large financial burden on households. Accordingly, I examine the settings in which long-term care is provided in Turkey in the next chapter.

As I have shown, all schemes administered by the SGK charge formal copayments for medical goods. Recent data on informal out-of-pocket payments does not exist, however, the share of households that paid any form of out-of-pocket payment increased from 41.9 percent in 2003 to 59.8 percent in 2009 (Yardımcı et al. 2014, 180). This may indicate that the share of the population that resorts to private healthcare providers has increased, however, further research is necessary to verify this claim. In sum, I observe that the family has lost the dominant role it once played in the financing of curative care. However, it is still a relevant actor in the financing dimension of the Turkish healthcare system. A number of governmental policies such as the 30-day waiting period before entitlement to services, and the exemption of insurants with premium debt, are underpinned by the principle that the family is responsible for the healthcare of its individual members.

I conclude that the reforms of the AKP government have led to visible changes in many of the healthcare financing schemes. In the following section, I summarize and systematically analyze the empirical findings of this chapter in order to validate the hypothesis that the political hegemony of the AKP government constitutes a critical juncture, which led to a paradigm shift in health care policy, and a system change in the actor constellation that constitutes the healthcare system of contemporary Turkey.

5.3 Intermediate results: The transformation of healthcare financing

In this chapter, I have examined the transformation of the financing dimension of Turkey's healthcare system. In the first section, I have shown that healthcare expenditure has rapidly increased since the AKP came to power. However, although per capita expenditure has increased from 656.80 U.S. dollars to 974.80 U.S. dollars between 2003 and 2015, Turkey still spends significantly less on healthcare than the mature European welfare states (OECD Health Statistics 2016). Expenditure is predominantly comprised of costs for curative care and medical goods. I have shown that self-medication and informal payments for pharmaceuticals in inpatient care significantly contribute to high levels of out-of-pocket payments. My findings furthermore indicate that public policies strengthen the role of households in healthcare financing and that state-owned institutions resort to informal out-of-pocket payments to reduce costs.

However, I have also noted that the share of households with catastrophic health expenditure has decreased since the AKP came to power. This suggests that the family has lost importance in healthcare financing. Particularly remarkable is that in international comparison; Turkish households run a low risk of catastrophic health expenditure despite the extraordinarily high level of out-of-pocket payments. This paradox can be partially explained by the reluctance of citizens in poorer segments of society to seek professional care, instead resorting to self-help or the help of others to overcome a health problem. These findings indicate a strong role of the family in healthcare provision, which I examine in the next chapter. Additionally, financial assistance across households may reduce the risks of catastrophic health expenditure. However, further research on the mechanisms of risk pooling and healthcare financing within Turkish families is necessary to validate this claim.

In the second section, I have delivered an in-depth analysis of changes in the healthcare financing schemes under the AKP government. Based on the SHA 2011, I have categorized and analyzed the different healthcare schemes that existed prior to the AKP reforms, as well as those that exist in contemporary Turkey. In order to validate the hypotheses that structure this study, my research has two objectives. First, to analyze the actor constellation within the respective schemes by categorizing financing agents and financing institutions according to institutions associated with the state, the market, non-governmental actors, or the family. Second, to reveal policy goals that underpin the respective schemes. Table 16 and 17 summarize the empirical findings of this chapter.

Table 16
Healthcare Financing Schemes in Turkey, year 2003

Scheme	Primary goal	Key actor		Coverage	Access to, utilization of services
		Financing agent	Financing institution		
Government preventive and outpatient curative care scheme	Access to rudimentary services for vulnerable groups	State, family	State, non-governmental, family	100%	Low
Government scheme for the poor	Access to rudimentary services for vulnerable groups	State, family	State, family	8.6%	Low
Government employee schemes for active and retired civil servants	Compensation of risks and costs related to sickness	State, non-governmental	State, family	12.5%	Average/high
Social insurance scheme for employees	Compensation of risks and costs related to sickness	Non-governmental	State, non-governmental, family	33.5%	Average
Social insurance scheme for the self-employed	Compensation of risks and costs related to sickness	Non-governmental	State, non-governmental, family	11.7%	Average
Voluntary health insurance schemes	Commodification of healthcare services	Market	Market, family	<1%	High
Household schemes	Strengthen capacity of the family to finance and provide healthcare	Family	Family	32.8%	Dependent on household resources

Source: Own depiction. Data on the coverage of the healthcare schemes is based on OECD and World Bank 2008.

Table 17
Healthcare Financing Schemes in Turkey, year 2014

Scheme	Primary goal	Key actor		Coverage	Access to and, utilization of services
		Financing agent	Financing institution		
Government preventive and outpatient curative care scheme	Create access to healthcare for the entire population	State	State, non-governmental, family	100%	Average
Government scheme for the poor	Create access to healthcare for vulnerable groups	Non-governmental	State, non-governmental, family	9.5%	Average
Government scheme for Syrian refugees	Create access to rudimentary services for vulnerable groups	State	State	<4%	Average
Compulsory social insurance scheme	Create access to healthcare for the entire population	Non-governmental	State, non-governmental, family	5.2%	Average
Government employee schemes for active and retired civil servants	Compensation of risks and costs related to sickness	Non-governmental	State, non-governmental, family	14.3%	Average
Social insurance scheme for employees	Compensation of risks and costs related to sickness	Non-governmental	State, non-governmental, family	50%	Average
Social insurance scheme for the self-employed	Compensation of risks and costs related to sickness	Non-governmental	State, non-governmental, family	18.8%	Average
Voluntary health insurance schemes	Commodification of healthcare services	Market	Market, family	3.4%	High
Household schemes	Strengthen capacity of the family to finance and provide healthcare	Family	Family	2%	Dependent on household resources

Source: Own depiction. Data on the coverage of the healthcare schemes is based on SGK online.

My findings show that in the early 2000s, healthcare financing was characterized by a high level of fragmentation. A multitude of health financing schemes coexisted and were administered by different financing agents and financed by a number of financing institutions. At the same time, they were underpinned by varying policy goals, which were shaped by the different ideological paradigms that dominated the political discourse throughout 20th century Turkey. However, the state only reluctantly engaged in the realm of healthcare. A mature welfare state that secures its citizens on the basis of social rights had not evolved and the transformation of the Turkish healthcare system was marked by path-dependency.

The schematic presentation of the empirical findings in this chapter highlights the key aspects of the transformation of the financing dimension of Turkey's healthcare system between 2003 and 2014. When focusing on changes in healthcare policy under the AKP government, three findings are crucial: First, changes in healthcare policy have significantly extended the coverage of the public healthcare system. Mandatory General Health Insurance was established with the goal of integrating previously excluded groups in society into the schemes administered by the SGK. Consequently, the role of household schemes has been reduced, however, while official data suggests universal coverage, this claim should be treated with caution. Certain groups in society continue to rely on their families to finance services. At the same time, certain healthcare functions, such as long-term care, also continue to be financed by households.

Second, inequalities in access to healthcare have been reduced. In this context, we can observe a change in the main policy goal of the government preventive and curative outpatient care scheme. While entitlement was legally based on citizenship; quality and utilization of services used to be extremely low. In practice, the policies behind the scheme aimed at financing a rudimentary service for the uninsured urban poor and the rural population. Under the AKP government, the policy goal behind the scheme has changed. The main aim of the new family physician system has been to provide universal access to free preventive and outpatient curative care.

A similar trend can be observed in the government scheme for the poor. The scheme was established with the goal of giving vulnerable groups in society access to rudimentary services. The benefits catalog excluded medical goods and access to specialized care in university hospitals was limited. The AKP implemented a number of policies, which established a single benefits catalog for all schemes and, subsequently, transferred the scheme to the SGK. In contemporary Turkey, all citizens who are covered by the schemes administered by the SGK are entitled to the same benefits catalog. Accordingly, I argue that the reform of the government scheme for the poor has to be understood as an integral part of the introduction of General Health Insurance which aims to create access to healthcare for the entire population.

Third, the policies of the AKP have further consolidated a two-tier public healthcare system. Within the first tier, the state administers and finances preventive and outpatient and curative care. Entitlement to services that are financed by the scheme is based on residence. Within the second tier, a non-governmental actor, the SGK, administers various government and social insurance schemes which provide access to services based on occupational or social status.

In sum, we can observe substantial policy changes in the financing dimension of Turkey's healthcare system. In the government preventive and curative outpatient care scheme, as well as the government scheme for the poor, we see a paradigm shift from a goal of providing basic care to vulnerable groups in society toward a goal of creating access to healthcare for the entire population.

In the government employee schemes and the social insurance schemes administered by the SGK, such a paradigm shift did not occur. The primary policy goal in these schemes remains at compensating individuals for the risks and costs of sickness based on occupational status. However, prior to the reforms, differences in benefits catalogs and entitlement criteria across the schemes created a social hierarchy among occupational groups. Furthermore, a significant share of the population relied entirely on household schemes to access care. Accordingly, I argue that the policies that established the General Health Insurance were primarily underpinned by one policy goal, which up to that point had played only a limited role in healthcare policy in Turkey: To create access to universal healthcare for the entire population. Accordingly, I conclude that the reforms of the financing dimension of the Turkish healthcare system that the AKP implemented within the framework of the HTP constitute a paradigm shift.

When examining changes in the actor constellation within the individual schemes, I have uncovered significant shifts in three schemes. In the government preventive and outpatient curative care scheme, the state has become the sole financing agent and is no longer complemented by the family. The state remains the main financing institution of the mostly tax-funded scheme, while the family has also lost importance. Medical goods are no longer exclusively financed by households.

Similarly, in the government scheme for the poor, we can observe a remarkable shift in financing agents from the state and family toward non-governmental actors. While the state's importance as a financing institution has increased, the family has lost relevance as medical goods have been included in the scheme's benefits catalog.

Furthermore, I have shown that the actor constellation of the government employee scheme for active civil servants has changed. Prior to the HTP, the scheme was administered by the respective state institution that employed the patient. In 2010, the scheme was transferred to the SGK which is now its key financing agent. However, this transformation did not have an effect on the mixture of revenues of the scheme which is financed predominantly by the state, with households contributing in the form of copayments for medical goods.

Changes within the actor constellations of the social health insurance schemes have been marginal. However, it should be highlighted that the state has gained importance in their funding. Prior to the reforms of the HTP, the central government contributed to the scheme by plugging its deficits. Since the reform of the social security law, the state makes additional contributions to the premiums of all SGK insurants by transferring an amount equaling 25 percent of the collected premiums (Tatar et al. 2011, 63).

Furthermore, governmental policies under the AKP government have established two new financing schemes: first, a government scheme that allows Syrian refugees to access medical care. The scheme is administered by the state and financed entirely through taxes. Second, a compulsory social insurance scheme that covers all uninsured citizens who are not entitled to benefits under the government scheme for the poor. The scheme is administered by the SGK and financed predominantly by premiums raised from households and state subsidies.

When focusing on voluntary health insurance schemes, the role of market actors in healthcare financing has increased marginally under the AKP government; however, their overall relevance remains limited.

The most significant transformation with regard to the actor constellation in healthcare financing can be seen in the role of the family. Since the AKP came to power, we can observe a remarkable reduction in the share of the population that relies on household schemes, which corresponds with the remarkable decrease in out-of-pocket payments over the last decade. However, certain segments in society continue to rely on household schemes to access inpatient care; and expenditure data indicates a strong relevance of the family in long-term care financing. Additionally, households contribute to the financing of all schemes administered by the SGK in the form of formal copayments.

In sum, changes in the actor constellation that constitutes the financing dimension of the Turkish healthcare system are mostly limited to shifts among the financing agents administering the schemes. With regard to the mixture of revenues of the respective schemes, my findings suggest only limited changes. The most significant transformation is the decreasing role of the family. However, as the only social safety net for those who are not covered by the SGK schemes, and as the sole financier of essential healthcare functions such as long-term care, the family's role remains vital.

Non-governmental actors, namely the SGK, have gained influence with the establishment of the new compulsory social insurance scheme. While expenditure data suggests a declining role of the state in healthcare financing, a number of policies show that the Turkish state's new commitment to socially protect its citizens is not limited to a regulatory role, such as the extension of the coverage of the government scheme for the poor; coverage of all under-aged citizens; substantial subsidies; and the establishment of a government scheme for Syrian refugees.

For a comprehensive test of the hypotheses that structure this thesis, I later complement the results of this chapter with those of the following chapters on provision and regulation of healthcare. Nevertheless, my preliminary empirical findings suggest the following:

(i) Results of in-depth analysis of the financing dimension of the Turkish healthcare system show that sub-hypothesis 1 - that the healthcare reforms of the AKP led to a system change in the actor constellation that constitutes Turkey's healthcare system - is not valid. While I have discovered significant shifts among the financing agents that regulate the respective schemes, their overall mixture of revenues has remained constant. A system change in healthcare, defined as a changeover of the predominant actors, did not occur in any of the schemes; (ii) However, I have shown that sub-hypothesis 1.3 - that the reforms of the AKP strengthen the role of non-governmental actors as financiers in Turkey's healthcare system - is valid; (iii) Likewise, my findings suggest that the reforms of the AKP have decreased the role of the family in healthcare financing and, hence, partly validate sub-hypothesis 1.4; (iv) I have presented empirical proof which validates sub-hypothesis 2 - that the healthcare reforms of the AKP lead to a paradigm change in healthcare policy. I substantiate this claim further in the following chapters by examining how healthcare policy instruments and their settings have been altered; (v) I have shown that the reforms of the AKP led to the emergence of a mature welfare state which protects its citizens from risks related to sickness on the basis of social rights and sub-hypothesis 2.2 can be considered valid. In the following chapter, I examine the transformation of the provision dimension of the Turkish healthcare system to further test the hypotheses that structure this thesis.

6. The transformation of healthcare provision

One of the unique characteristics that sets healthcare apart as a social policy is its emphasis on service delivery. In contrast to other programs of the welfare state, means transfers play a minor role in healthcare systems, where the primary function is caring for the sick. Despite this significance, the provision dimension has, at least until recently, been neglected in the literature on healthcare system analysis (Wendt et al. 2009, 73).

A number of studies highlight the significant increase in the quantity and quality of institutions providing healthcare in Turkey since the launch of the HTP.⁹⁴ In this section, I attempt to systematically analyze how the role of the various actors in healthcare provision, i.e., the state; the market; non-governmental actors; and the family, have changed since the AKP came to power. I also evaluate changes in the related policies and employ the key indicators of ownership and profit orientation in order to categorize healthcare providers.

To guarantee the comparability of the results, the analysis is structured according to the classification of healthcare functions and providers offered by the SHA 2011.⁹⁵ In particular, the system identifies the following healthcare functions: (i) curative care; (ii) rehabilitative care; (iii) long-term (health) care; (iv) ancillary services; (v) medical goods; (vi) preventive care; and (vii) governance and administration.⁹⁶ Each of these functions can be separated into four different modes of provision categories: (i) inpatient care; (ii) day care; (iii) outpatient care; and (iv) home-based care (OECD et al. 2011, 389-90).

Furthermore, the SHA 2011 offers a comprehensive classification of provider categories. It distinguishes between primary providers whose principal activity is to deliver care within the different functional classes and secondary providers, which deliver healthcare in addition to their principal activities that might not be related to healthcare at all. The key categories for primary providers are: (i) hospitals; (ii) residential long-term care facilities; (iii) ambulatory care providers; (iv) ancillary services providers; (v) retailers and other providers of medical foods; and (vi) preventive care providers. Examples of secondary care providers may be residential care facilities, which focus on the provision of accommodation but also provide nursing services as a secondary activity; or supermarkets which sell

⁹⁴ For an overview of reforms in healthcare provision and their outcomes see: Barış et al. 2011; OECD and World Bank 2008, 50-53; OECD 2014, 33-114; Tatar et al. 2011, 113-46.

⁹⁵ Most existing studies analyze healthcare provision by establishing functional categories, e.g., the European Observatory on Health System and Policies offers the following categories as a framework of healthcare provision: public health, patient pathways, primary and ambulatory care, specialized ambulatory care and inpatient care, day care, emergency care, pharmaceutical care, rehabilitation and intermediate care, long-term care, services for informal carers, palliative care, mental healthcare, dental care, complementary and alternative medicine, health services for specific populations (Rechel et al. 2010)

⁹⁶ To show how the state, the market, non-governmental actors, and the family interact in the provision of healthcare, I focus on (i) curative care; (ii) rehabilitative care; (iii) long-term (health) care; (iv) medical goods; and (vi) preventive care. I neglect the healthcare functions ancillary services and governance and administration.

over the counter medical goods. Furthermore, and most importantly in the context of this analysis, households are classified as secondary care providers (Ibid., 123).

The SHA 2011 aims to provide an accounting tool to help assess and monitor the economic performance of healthcare systems (OECD and WHO 2014, 6). In contrast, my study focuses on the social and political embeddedness of healthcare systems. Therefore, I use the healthcare functions and provider categories defined by the SHA 2011 to examine policy change and transformations in the roles of the state, the market, non-governmental actors, and the family in the provision dimension of the Turkish healthcare system. By elaborating on the analytical framework offered by Wendt et al., I use ownership criteria and profit orientation of healthcare providers as indicators to categorize the actors (Wendt et al. 2009, 79). For example, I argue that a larger share of hospital beds in state-owned hospitals indicates a strong role of the state in inpatient curative care provision.

While these indicators are helpful analytical tools in examining the actor constellation that constitutes the provision dimension of Turkey's healthcare system, their explanatory power is limited. Medical treatments commonly consist of healthcare packages provided by a variety of actors (OECD et al. 2011, 61). Accordingly, although a patient receives inpatient treatment in a state-owned hospital, he or she may resort to services provided by market or non-governmental actors, as well as family members. Furthermore, the level of commodification of healthcare services cannot be derived from ownership criteria alone. For example, general practitioners in the British NHS are mostly self-employed and many work in private practices. However, their services are commonly financed through taxes (Moran 2000, 143). Accordingly, the findings of this chapter have to be put into context with the results of Chapter 5 and 7.

My findings in the previous chapters indicate a transformation in healthcare provision since the AKP came to power. By classifying Turkey in Schieber's typology, I have revealed that the hospital sector in Turkey shares key characteristics with the National Health Service Model, namely high levels of state control and ownership. However, over the last decade I have detected a remarkable increase in market-owned hospital beds.

Additionally, my preliminary findings indicate a strong role of the family in healthcare provision. A significant share of the population resorts to self-help or the help of non-professionals to overcome a health problem. Furthermore, the absence of official data on long-term care expenditures and high levels of self-medication indicate that the family is an important provider of medical care. Taking these findings into account, my aim in this chapter is to highlight changes in healthcare provision that indicate policy change, and to examine further the transformation of the actor constellation that constitutes the Turkish healthcare system.

In the following, I analyze in detail how healthcare policies and the actor constellation that constitutes the Turkish healthcare system have changed since the AKP came to power.

6.1 Curative care

The SHA 2011 defines curative care as “healthcare contacts during which the principal intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury, or to protect against exacerbation and or complication of an illness and or injury that could threaten life” (OECD et al. 2011, 84). Structured by the categories of healthcare functions and providers offered by the SHA 2011, I analyze how the role of the state, the market, non-governmental actors, and the family, has changed in curative care provision since the launch of the HTP.

6.1.1 The transformation of inpatient curative care

Inpatient contacts are “formal admission into a healthcare facility for treatment and/or care that is expected to constitute an overnight stay” (Ibid., 79). Inpatient care is irrespective of the type of provider and comprises all goods and services a patient receives during his or her inpatient contact.

In the Turkish context, hospitals have been the key primary providers of inpatient curative care.⁹⁷ Prior to the HTP, some of the state-owned facilities that were financed by the government preventive and curative outpatient care scheme also provided short-term inpatient care (World Bank 2003a, 67). Specific data on curative care contacts made in Turkish hospitals is not available. However, later in this chapter I demonstrate that the share of hospitals and hospital beds that serve rehabilitative or long-term functions has been marginal. Accordingly, in this section, I use data from the general hospital sector to analyze the transformation of curative inpatient care provision in Turkey.

Since the launch of the HTP, the capacities of the Turkish hospital sector have grown significantly. Between 2000 and 2013, the total number of hospitals increased from 1,226 to 1,517. Over the same period, the number of hospital beds increased from 150,855 to 202,031 (Ibid., 13; MoH 2014, 71).

As discussed in the historical analysis, regional disparities in the distribution of hospitals led to massive inequalities with regard to access to healthcare. In 2000, 26 percent of Turks lived in Istanbul, Ankara and Izmir. At the same time, hospitals in these cities accounted for 36 percent of the total of hospital beds and employed 50 percent of hospital doctors (World Bank 2003b, 65).

Turkey is among the lowest providers of hospital beds per inhabitant in the OECD. In 2014, there were 2.68 beds per 1,000 inhabitants, just over half the OECD average of 5.0. However, the rate had increased from 2.2 in 2003 (OECD Health Statistics 2016). Between 2003 and 2013, we can observe a marked increase in the number of hospital beds in southeastern Anatolia, from 1.26 to 2.02 beds per

⁹⁷ Within the hospital category, the SHA 2011 distinguishes between general hospitals, mental health hospitals and other specialized hospitals. However, mental hospitals as well as some of the other specialized hospitals predominantly provide long-term services and rarely engage in curative care (OECD et al. 2011).

1,000 inhabitants. However, regional disparities are still clearly visible. In western Anatolia the share has increased from 2.89 to 3.44 during the same period (MoH 2014, 73).

In terms of ownership criteria and profit orientation, one of the key characteristics of the hospital sector in Turkey prior to the HTP has been the high level of state ownership. In 2000, state institutions, such as the MoH and universities, owned 69.1 percent of hospitals and 73.9 percent of hospital beds.⁹⁸ Non-governmental actors, such as the SSK and non-profit foundations, owned 11.8 percent of hospitals and 19.4 percent of hospital beds. For-profit hospitals accounted for 19.1 percent of all hospitals and comprised 6.7 percent of total hospital beds (World Bank 2003a, 13).

Earlier data suggests that the rise of the liberal conservative paradigm had a significant impact on inpatient provision in Turkey. Prior to the 1990s, for-profit hospitals played a marginal role but toward the end of the century their importance increased. Between 1995 and 2000, the number of hospital beds run by market actors doubled to 11,667 (Ibid., 13-16). Nevertheless, prior to the HTP, for-profit actors provided care predominantly for wealthier citizens living in urban Turkey. Private hospitals were concentrated in the three largest cities and, in 2000, more than half of the 234 for-profit private hospitals were located in Istanbul (Ibid., 17).⁹⁹

As shown in Table 18, a decade after the introduction of the HTP, we can observe significant changes with regard to ownership of hospitals and hospital beds.

Table 18
Ownership of hospitals and hospital beds as a percentage, years 2000 and 2013

	Ownership of hospitals, year 2000	Ownership of hospitals, year 2013	Ownership of hospitals beds, year 2000	Ownership of hospitals beds, year 2013
MoH	60.7	56.3	45.8	60.0
SSK	9.6	--	18.1	--
University	3.4	4.5	15.8	17.8
Other public institutions	5.0*	2.9**	12.3*	3.3**
For-profit	19.1	36.3	6.7	18.8
Non-profit	2.2	--	1.4	--

Notes: *including municipality-owned hospitals **including non-profit foundation and municipality-owned hospitals
Source: World Bank 2003a; MoH 2014.

In 2013, the state was still the key provider of inpatient care, owning 60.8 percent of the 1,517 hospitals and 77.9 percent of the 202,031 hospital beds in Turkey. However, although all SSK hospitals had been transferred to the MoH, which opened 80 new hospitals, the overall share of hospitals owned by the ministry decreased between 2002 and 2013. Likewise, the share of hospitals and

⁹⁸ These numbers include municipality-owned hospitals.

⁹⁹ This number excludes 18 foundation hospitals and 9 hospitals belonging to ethnic and religious minorities. Total number of private hospitals in 2000 was 261.

hospital beds managed by other public actors, such as the Ministry of National Defense (*Milli Savunma Bakanlığı*), has decreased (MoH 2014, 71).

These changes indicate a significant strengthening of the role of market actors in healthcare provision. Between 2000 and 2013, the share of private hospitals almost doubled to 36.3 percent, while the share of private beds almost tripled to 18.8 percent. In 2002, 12,387 hospital beds were owned by private for-profit and non-profit actors. By 2013, that number had more than tripled to 37,983 (Ibid., 71). The vast majority of for-profit hospitals are owned by large hospital groups. The biggest actors are the Medical Park group with 15 hospitals and 2,780 beds, and the Acıbadem Group, which owns 11 hospitals with more than 1,400 hospital beds. The 10 biggest hospital groups together owned approximately 9,129 hospital beds in 2011, which amounted to 28.8 percent of beds in private facilities (Deloitte Türkiye and Uluslararası Yatırımcılar Derneği 2012, 33).

The increasing share of for-profit inpatient care institutions corresponds to higher numbers of patients seeking inpatient care and services at these facilities. The total number of patients that had inpatient contacts in facilities not owned by the state, increased from 5.5 million to 12.4 million between 2002 and 2013. Over the same period, the share of patients that sought care in private inpatient care facilities has risen dramatically from 10.1 percent to 30 percent. Likewise, while the total number of surgeries almost tripled from 1.6 million to 4.7 million between 2002 and 2013, the share of operations performed in private facilities increased significantly from 13.6 percent to 33.1 percent (MoH 2014, 105). Accordingly, while the total number of annual consultations per capita at hospitals increased from 1.9 to 4.9 between 2002 and 2013, the share of consultations in private settings has more than tripled from 5.2 percent to 18.3 percent (Ibid., 102). These numbers further emphasize the massive growth of the healthcare market in Turkey since the AKP came to power.

It needs to be emphasized that average stays are significantly higher in state-owned hospitals. The average stay in MoH hospitals decreased from 5.7 days to 4.4 days. Over the same period, stays in private hospitals have dropped from 3.1 days to 2.2 days (Ibid., 110). I assume that high costs for services provided in for-profit facilities contribute to shorter stays in these facilities, however, further research is necessary to verify this claim.

Ownership alone does not necessarily define who provides care in inpatient settings. As already discussed, one of the specific traits of healthcare provision in Turkey is the low share of healthcare professionals per inhabitant. Although the number of healthcare providers has increased significantly since the AKP came to power, the number of nurses and midwives per inhabitant, in particular, are extremely low when compared to European welfare states.¹⁰⁰ In 2013, there were an average of 836

¹⁰⁰ Between 2002 and 2013, the number of health professionals significantly increased. The total number of physicians, including primary care, increased from 91,949 to 133,775; the number of nurses increased from 72,393 to 139,544; and the number of midwives increased from 41,479 to 53,427. In 2013, 45,898 physicians

practicing nurses and midwives per 100,000 inhabitants in the EU, compared to Turkey where that number was 252, below the global average of 292 (Ibid., 145).

The absence of professional care providers in hospital settings highlights a remarkable feature of the Turkish healthcare system. Patients in inpatient care have the legal right to be accompanied by a *refakatçi* (companion). According to the Regulation on the Administration of Inpatient Care Institutions (*Yataklı Tedavi Kurumları İşletme Yönetmeliği*) from 1973, this person is allowed to stay with the patient during the entire duration of the hospital stay.

Only few studies have investigated the role of the *refakatçi* in the Turkish healthcare system. A study conducted at a university hospital in Izmir in 1999 found that the vast majority of companions were female and close relatives of the patients.¹⁰¹ When asked why they stayed with the patient, 90.8 percent of the respondents stated they were worried the patient was incapable of meeting his or her daily needs without assistance; 67.9 percent considered their stay as a duty; 63.3 percent wanted to get more information about the patient's health; and 47.7 percent wanted to assist with the medical care provision of the patient. Only a fraction of the respondents - 0.8 percent - were reimbursed for their services, while 76.1 percent of *refakatçi* belonged to the patient's nuclear family (Güldal et al. 2001, 19-20).

The study shows that a significant share of *refakatçi* stay with the patient because they consider the formal psychological and physical assistance provided by the hospital staff insufficient. About half of the *refakatçi* defined their services as medical care provision. At the same time, 68.5 percent did not receive any kind of training or instructions (Ibid., 19).¹⁰²

A more recent study on the role of families in inpatient care conducted by Evren and Ökten in a hospital in Istanbul comes to similar conclusions.

[F]amily care provides an essential element, supplementing inputs of skilled hospital labour and medical supplies that would otherwise be insufficient. [...] Hospital managements have been filling the gap by involving patients' families. Where personnel and/or supplies at public hospitals are scarce, and formal outsourcing remains insufficient, families increasingly provide direct support. This takes the form of provision of medical supplies, and caring labour (Evren and Ökten 2011, 97).

worked in MoH hospitals, amounting to 32 percent of all physicians, while 28,312 physicians worked in university hospitals, amounting to 21.2 percent of all physicians. Data on the share of physicians working in private inpatient care facilities is not available. The total number of doctors working in privately owned facilities, including primary care, was 28,466, which amounts to a share of 21.28 percent of all physicians (MoH 2014, 137).¹⁰¹ Of the 130 *refakatçi* interviewed, 79.1 percent were women and 76.1 percent were first degree relatives and 18.5 percent were second degree relatives. Only 5.4 percent of the *refakatçi* were friends, neighbors, for-profit caregivers, or military commanders. Of the *refakatçi* interviewed in the study, 46.2 percent had primary school education, 24.6 percent middle and high school education, and 29.2 percent had university degrees.

¹⁰² When asked what kind of duties they performed while serving as *refakatçi*, 92.3 percent stated that they gave physical assistance and 91.5 percent said they provided psychological assistance to the patient. A further 40.8 percent stated that they contributed to medical care provision and 61.5 percent said they ensured that the patient was transported safely to examinations etc.

A high-ranking employee at the nursing department affiliated to Istanbul University, whom I interviewed for this thesis, stated that in her hospital, *refakatçi* were commonly not included in medical care provision, such as changing bandages, medication, or washing of patients. She stressed that patients who are not accompanied by family members are not disadvantaged and have equal access to care. However, she highlighted that nurses integrate *refakatçi* into medical healthcare provision if the patient is reliant on family care once released. Accordingly, *refakatçi* of hospitalized long-term care patients were informally trained by the hospital staff to provide nursing services at home. According to her observations, the vast majority of *refakatçi* in her hospital were first degree female relatives of the patient. However, some of the patients hired for-profit companions who were mostly female migrants.¹⁰³

Another example of the cultural and social importance of the family in inpatient care is the practice that relatives spend the night inside or in front of the hospital. A study conducted in 2010 and 2011 among relatives of patients receiving care at the university hospital in Gaziantep shows that almost 50 percent of those interviewed had spent more than 11 days in front of the hospital (Al et al. 2013, 20).

Yiğit Evren and Ayşe Nur Ökten show how the informal inclusion of family members in hospital care and out-of-pocket payments in inpatient settings stimulates the growth of businesses that sell medical goods in the area around hospitals (Evren and Ökten 2011). These findings further illustrate how the role of the state, the market, and the family are interwoven in healthcare financing and provision.

In sum, based on ownership criteria, I have shown that the state remains the key provider of inpatient curative care. Prior to the HTP, inpatient curative care was characterized by a high level of fragmentation and significant structural deficits. Quality of and access to services was limited. Providers clustered in the large western cities and regional disparities further increased inequities in the healthcare system. Under the AKP, we can observe a significant increase in the quantity and quality of the institutions that provide inpatient care. At the same time, utilization rates have improved, however, in cross-national comparison Turkey still lacks behind.

When focusing on ownership and profit orientation I have shown that the number and capacities of state-owned facilities have increased. However, the overall share of state-owned facilities has dropped and we can observe a significant increase in market ownership. For-profit hospitals have become an integral part of inpatient curative care provision with one-fifth of hospital beds currently owned by private, and predominantly for-profit actors. These facilities account for one-third of inpatient contacts and surgeries. With the transfer of SSK hospitals to the MoH, the role of non-governmental actors in healthcare provision has been marginalized

¹⁰³ The interview was conducted in July 2013. The interviewee's name has been withheld at her own request. I have conducted a total of seven interviews with healthcare professionals and social policy experts for this thesis. While the data I have gathered during the other interviews has served as background information, I directly refer to this interview alone.

Furthermore, my analysis emphasizes a striking characteristic of inpatient healthcare provision in Turkey. To date, family members have been systematically integrated into medical care provision in state-owned facilities. In addition to the fact that family members are often obliged to finance medical goods in inpatient settings through out-of-pocket payments, the *refakatçi* system is a striking example of how the family's role in the Turkish healthcare system is strengthened and reproduced by healthcare policies. At the same time, the strong role family members play in inpatient care provision partly explains the chronically low numbers of healthcare professionals, in particular nurses, in Turkey.

6.1.2 The transformation of day care

Day care involves a formal admission to a health facility. However, in contrast to inpatient care, medical services are planned and delivered to patients on the day of admission. Day care may be provided in various settings, and provision facilities are commonly established to serve specific objectives in health policy, such as the reduction of costs or waiting time. In most countries, day care services are underdeveloped (OECD et al. 2011, 79). Likewise, curative day care in Turkey is incipient. While some facilities that offer services to the disabled also offer rehabilitative services, data on curative day care provision does not exist (Tatar et al. 2011, 131).

6.1.3 The transformation of outpatient care

The SHA 2011 defines outpatient care as “medical and ancillary services delivered to a patient who is not formally admitted to a facility and does not stay overnight” (OECD et al. 2011, 80). It can be provided in a variety of settings, such as the outpatient departments of hospitals, ambulatory care centers, a physician's practice, but never at a patient's home.

Prior to the HTP, outpatient curative care was predominantly provided through the network of facilities run by the MoH. The SSK ran its own network of outpatient care facilities. Furthermore, outpatient departments of hospitals, as well as for-profit polyclinics and private practices, were relevant providers.¹⁰⁴

The MoH ran a network of different types of outpatient facilities.¹⁰⁵ In 2000, this network comprised of 11,675 health posts and 5,700 health centers. Significant regional differences with regard to the

¹⁰⁴ For an overview see: World Bank 2003a, 10-13; Savaş et al. 2002, 66-69.

¹⁰⁵ According to the Socialization of Health Services Law from 1961, health houses (*sağlık evi*) were to be staffed with a midwife who attended deliveries and provided maternal care, as well as general primary care to a population of 2,000-2,500 citizens. Health posts (*sağlık ocağı*) in rural areas provided care to 5,000 to 10,000 citizens and were to be staffed with one physician, a nurse, a health officer, two midwives and support staff. Health posts in urban areas provided care to 10,000 to 30,000 citizens and were staffed with 16 health

number of people covered per health center can be observed. Health centers in Istanbul covered an average of 48,000 citizens while their counterparts in south and southeastern Anatolia only covered an approximate of 4,000 citizens (World Bank 2003b, 51).

Lack of funding led to low quality of services and dramatic understaffing. In 2000, 12 percent of health posts were not staffed with a physician and 66 percent of health houses were, in practice, dysfunctional as no midwife was appointed to them. Staff shortages among outpatient care facilities varied significantly between rural and urban areas as well as between regions. While 77 percent of assigned positions in urban areas were, in reality, staffed with doctors, the ratio in rural areas was as low as 54 percent. Similarly, 78 percent of planned positions for nurses and 73 percent for midwives in urban areas were staffed, while in rural areas, 42 percent of planned positions for nurses and 53 percent for midwives were staffed. In consequence, many patients received services provided in hospital outpatient departments (Ibid., 52-55).

With regard to regional disparities, imbalances between the underdeveloped southeast of the country and the industrialized western regions were striking. In 2000, 20 percent of health posts in southeastern Anatolia were not staffed by a physician, and 84 percent of health houses were not staffed by a midwife. In the Aegean region, only 7 percent of health posts were not staffed by doctors. The ratio of MoH doctors was one for every 3,123 inhabitants in the Aegean region, while it was as low as one doctor for every 6,430 inhabitants in southeastern Anatolia (Ibid., 53-54).

In addition to these facilities, several other state-owned facilities provided outpatient care. The most important of these were outpatient departments run by MoH and university hospitals. Furthermore, the Ministries of Education and Transport, as well as a number of municipalities, owned facilities which provided curative outpatient care to specific groups in society (World Bank 2003a, 10-13).

General hospitals, and in particular hospitals run by the MoH, accounted for the vast majority of outpatient contacts made in hospitals. Due to the low quality of services provided at the ministry's curative outpatient facilities, many patients preferred to attend hospitals. In 2000, the number of outpatient visits per capita to health centers was 0.8, compared to 1.6 for outpatient departments in hospitals (OECD and World Bank 2008, 57). In the absence of a referral chain, patients could consult general practitioners and specialists working in hospitals at any time, which often led to long waiting times (Erus and Aktakke 2012, 339).

Complementary to the MoH preventive and curative outpatient care facilities, the SSK ran its own network that in 2000, comprised of 219 health posts and 189 dispensaries. These facilities were mostly located in the industrial areas of Turkey and provided services to SSK, as well as *Emekli Sandığı* and *Bağ-Kur*, members (World Bank 2003b, 50).

professionals including four physicians, two nurses and two midwives. Health centers (*sağlık merkezi*) were staffed with 22 health professionals and six support staff and served 30,000 to 50,000 citizens.

While the MOH preventive and outpatient curative care facilities were predominantly used by rural Turkish citizens and the urban poor, most patients consulted hospital outpatient departments when sick. At the beginning of the 2000s, SSK insurants had to visit the agency's own facilities. *Bağ-Kur* and *Emekli Sandığı* insurants had the right to choose between university, MoH and SSK hospitals. More than 90 percent of patients visited hospital outpatient departments without a referral from MoH or SSK primary care facilities (Ibid., 60).

Facilities run by market actors, such as private practices, private polyclinics, and medical centers also provided outpatient curative outpatient care services. These services were predominantly financed through patient out-of-pocket payments.

Reliable data on the number of private outpatient care facilities is scarce and does not exist for private healthcare practices. In fact, prior to the HTP, the majority of Turkish physicians worked in private and public settings and, as I show later in the next chapter, state regulation of the private sector was traditionally low.

The share of state-employed physicians with an auxiliary income in the private sector increased significantly during the 1990s. In 1990, only 24 percent of Turkish doctors worked exclusively in public facilities and 40 percent in private facilities. About 36 percent worked in public healthcare and private institutions (Tokat 1993, 37). In 1996, 14 percent of doctors worked in private settings, 28 in public settings and 58 percent in both public and private settings (Tokat 1998, 45). The opportunity to work in private settings allowed doctors in Turkey to increase their chronically low public sector wages. However, it raised significant moral and ethical problems in the Turkish healthcare system and made outpatient care especially susceptible to corruption. This put a significant additional burden on the family and discouraged patients from seeking professional medical assistance when sick (World Bank 2003b, 79).

Although the exact numbers are unknown, it can be assumed that private curative outpatient facilities were concentrated in the industrialized western parts of Turkey. In 1998, about 65 percent of doctors, who worked exclusively in private settings, were based in the western Aegean and Marmara regions. Only 1 percent of private doctors worked in the east or southeast of the country (Ibid, 79). Similarly, private hospitals and polyclinics, which mushroomed in the 1990s, were located in the urban areas of western Turkey. In the early 2000s, about two-thirds of the 1,500 private polyclinics were located in the three biggest Turkish cities, Istanbul, Ankara, and Izmir (Ibid., 81). Accordingly, regional disparities led to significant inequalities with regard to the access to preventive and outpatient curative care. As MoH facilities were poorly staffed and equipped and private facilities were scant in the eastern and southeastern regions, I surmise that many patients relied on medical assistance provided by family members.

In sum, prior to the HTP, the state was the key actor in the provision of curative outpatient care. It ran a network of facilities across the country, which was complemented by state-owned hospitals. The role of market actors increased from the 1990s onwards and a significant share of the population sought care in the outpatient departments of for-profit hospitals, as well as at private practices and polyclinics. However, these facilities were concentrated in the larger cities in western Turkey. Furthermore, a significant share of state-employed doctors in Turkey earned an auxiliary income from services provided in private settings. These services were predominantly financed through household schemes and, hence, contributed to the high burden of out-of-pocket payments on households. Non-governmental actors, namely SSK facilities and non-profit hospitals owned by foundations, played a limited role. As a significant share of the population had no access to professional outpatient care, I surmise that many Turks relied on services provided by the family.

The reforms of the HTP aimed at a fundamental reorganization of outpatient care provision (MoH 2003, 30-31). Between 2005 and 2010, the tax-funded facilities run by the MoH were gradually replaced by a network of family medicine-based providers (Tatar et al. 2011, 67).

Since the reform, the employment status of family physicians has changed from civil servant to self-employed. However, the state strictly regulates family physicians, which I discuss further in Chapter 7. The majority of family physicians rent state-owned facilities. Accordingly, when focusing on ownership criteria, the introduction of the family physician system has not brought about significant changes. However, physicians have the right to provide services in private practices (World Bank 2013).

Over the last decade, so called family health centers (*aile sağlığı merkezi*) and community health centers (*toplum sağlığı merkezi*) have been established. At current state, family health centers are responsible for the provision of preventive, prenatal, postnatal, and family planning services, as well as outpatient curative care, diagnostic services, rehabilitative care, and counseling services. According to the Family Medicine Law, services are provided free of charge to those citizens who are registered with a family physician working at the respective facility. In 2013, the average number of registered patients per physician was as high as 3,500 (Ibid., 4).

Community health centers are erected by the MoH's District Health Directorates. They provide diagnostic services and medical tests as well as specialized services, which are not provided by family physicians, such as emergency care. Additionally, they serve as training centers and as logistical support and supervision to family health centers, and also provide public health services, such as health training, disease control, and data collection on public health matters (Tatar et al. 2011, 122-24).

The reform of outpatient curative care was backed by a significant increase in public funds. Between 2002 and 2011, the allocated resources for public and primary care increased 2.7 fold in real terms (MoH 2012, 24). According to MoH data, the number of physicians working in public outpatient care

facilities, namely family health centers and community health centers, increased from 17,800 to 22,733 in 2011 (Ibid., 108). Regional disparities with regard to the ratio of physicians per capita were significantly reduced. In Istanbul, the ratio decreased from 8,624 citizens per doctor in 2002 to 3,883 in 2011. In the chronically understaffed public health facilities in southeastern Anatolia, the ratio decreased from 5,218 to 3,848 citizens (Ibid., 109).

I surmise that other state institutions, such as MoH and university hospitals, continue to play a significant role in outpatient care provision. However, data on the number of contacts and their total share is not available.

The role of societal actors in curative outpatient care provision has decreased since the implementation of the HTP. The network of outpatient care facilities run by the SSK was dissolved and replaced by the family physician system. As I have discussed earlier in this chapter, only a small number of hospitals owned by non-governmental actors exist.

Data on the role of for-profit providers in the provision of curative outpatient care is scarce. What appears remarkable is the fact that the number of outpatient contacts in private polyclinics has decreased from almost 2.5 million in 2010 to about 580,000 in 2013 (MoH 2014, 97). These numbers suggest that the role of the market in outpatient curative care has decreased significantly with the introduction of the family physician system. However, data on the number of outpatient contacts made in private hospitals and their total, which would help verify this claim, is not available.

6.1.4 The transformation of home care

Medical home care comprises medical, ancillary and nursing services which are provided in the patient's home. Home care requires the physical presence of a healthcare provider. Services may be provided by a healthcare professional but also by a relative or a community trained worker (OECD et al. 2011, 81).¹⁰⁶

Data on medical home care provision prior to the HTP is limited to services carried out by healthcare professionals working in MoH institutions. I surmise that private physicians and other healthcare professionals also provided home care services. Taking into account that private practices were almost exclusively located in western urban areas and were attended predominantly by wealthier segments of society, access to private home care can be considered limited. However, data to support my claim is not available.

¹⁰⁶ The SHA 2011 differentiates between medical and social care. This paragraph focuses on the transformation of medical home care. Over the last few years, the AKP implemented a number of reforms with the aim of strengthening social care, particularly for the elderly and the disabled (Çoban et al. 2014).

Prior to the 1960s, home care, just like public healthcare in general, was predominantly understood as a means to build a healthy nation. Accordingly, a number of regulations mentioned home care that aimed at the containment of disease, as well as natal and childcare. With the shift from preventive to curative care during the 1960s, policy makers discussed home care as an integral part of outpatient and inpatient care (Çoban et al. 2014, 155-56). Home care was explicitly mentioned in the first five-year development plan as an alternative to inpatient care and as a way to improve access to services (Devlet Planlama Teşkilatı 1963, 39). Under Article 10 of the Socialization of Health Services Law, personnel staffing the network of preventive and outpatient curative care facilities across the nation were instructed to deliver free home care services to patients in their area. Since the late 1960s, there have been a number of legal changes and pilot projects aimed at strengthening the provision of specialized care services at home.¹⁰⁷

However, prior to the HTP, home care services financed and provided by the public healthcare system, have to be considered as rudimentary. Physicians, as well as midwives and nurses that staffed the network of preventive and outpatient curative care facilities, sporadically provided home care services to patients living in their catchment area. In light of the dramatic understaffing and low financing of these facilities, access to these services must be considered severely limited. A report by the World Bank highlighted that healthcare personnel commonly lacked means of transportation to visit patients in remote areas (World Bank 2003a, 63-64).

As a consequence of the lack of state, market, and non-governmental actors in curative care, a significant share of Turks relied on informal care networks when in need of medical care. In the early 2000s, 19.8 percent of births in eastern Anatolia were not attended by a health professional (World Bank 2003b, 53).

This further substantiates the assertion that prior to the AKP reforms the family played a significant role in healthcare provision. Given that a large share of the population did not seek professional care when sick, self-medication was common, and a large share of women did not consult a doctor during pregnancy, it can be assumed that many patients relied on the capacity and willingness of family members to provide care.

Since the launch of the HTP, a number of policies were implemented which aim at improving home care provision in Turkey. According to MoH data, in 2010, only 16,651 patients received home care provided by health professionals bound to the MoH. By December 2014, this number had increased to 510,352. Over the same period, the number of home care units increased from 407 to 915 and the number of health professionals from 478 to 4,605 (MoH 2015, 48).

¹⁰⁷ For an overview see: Ibid.; Karabağ 2007.

While home care provision by state actors has increased, little data exists on the role of market actors in the field. There is no data available on the number of home visits made by private physicians working for-profit. My findings, furthermore, suggest that the family continues to be the main provider of medical home care in Turkey. However, very little empirical data exists that would allow insight into the mechanisms of informal medical care provision in Turkish homes.¹⁰⁸

In sum, since the implementation of the HTP, formal curative home care has gained momentum. Recently passed regulations have established a comprehensive institutional structure, which at least in theory, provides access to home care provision. Likewise, the importance of public home care provision can be expected to grow in the future. In the MoH five-year strategy for the years 2015 to 2020, the need for more professional home care is emphasized (Ibid., 8). I discuss the related policies implemented by the AKP government and the new complementary role of the state in further detail in Chapter 7. However, despite these reforms, the role of the state in contemporary home care provision is limited. The analysis of recent expenditure data provided in the previous chapter validates this claim. Although we can observe a slight increase in expenditure for home care over the last few years, it remains marginal.

6.2 Rehabilitative care

Rehabilitative care is a set of specific interventions which are defined in a rehabilitation plan and aim at achieving specific medical goals. The scope of medical conditions treated by rehabilitation services is wide. Accordingly, it comprises a variety of services. In congruence to curative care, the SHA 2011 classifies services according to the setting of their delivery, namely inpatient care, day care, outpatient care, and home-based rehabilitative care (OECD et al. 2011, 87-88).

Rehabilitative care has remained significantly underdeveloped in Turkey. In 2003, the number of physiotherapists per 100,000 inhabitants was as low as 7.7, while the EU average was 80.2. Despite the obvious demand for more professionals providing rehabilitative services, the number of graduates from physical therapy and rehabilitation schools remains low. In 2002 to 2003, a total of 299 physiotherapists received their license. By 2012 to 2013, this number had increased to 595. However, the number of graduates from higher education rehabilitation and physiotherapy programs decreased from 227 in 2003 to 2004 to 199 in 2012 to 2013 (Yükseköğretim Kurulu 2014, 90-93).

Inpatient rehabilitative care in Turkey has been predominantly provided in state facilities. In 2000, prior to the HTP, the MoH owned 11 Physical Therapy and Rehabilitation Hospitals with a total capacity of 1,340 beds. When compared to the total bed count, the share of rehabilitative care beds

¹⁰⁸ A study by Mehmet Zencir et al. focuses on long-term home care provision for patients with Alzheimer's disease (2005).

was below one percent (Tatar et al. 2011, 88). Data on university hospitals and general hospitals owned by the ministry is not available but it can be assumed that they provided rehabilitative care services.

In addition to MoH facilities, the Agency for Social Services and Child Protection (*Sosyal Hizmetler ve Çocuk Esirgeme Kurumu, SHÇEK*), ran a network of long-term care centers which provided inpatient rehabilitative services to the elderly and the disabled. In 2002, the number of centers was 21 (Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü 2015, 7).

While the number of rehabilitative hospitals and beds has increased over the last decade, state dominance in inpatient rehabilitative care persists. By 2013, the number of Physical Therapy and Rehabilitation Hospitals run by the MoH was 16, with a total capacity of 2,078 beds. However, the share of rehabilitative care beds is consistently low and accounts for approximately one percent of the total bed stock (MoH 2014, 72). In addition to hospitals that have specialized in rehabilitative care, a number of general hospitals provide services in physiotherapy and rehabilitation in their wards (Tatar et al. 2011, 138).

In 2011, the SHÇEK was dissolved and its facilities were transferred to the Ministry for Family and Social Policy (*Aile ve Sosyal Politikalar Bakanlığı*). In 2014, the ministry ran a network of 85 Care and Rehabilitation Centers and 86 Hope Houses (*umutevi*) which provide inpatient rehabilitative care. However, in congruence to the facilities of the SHÇEK, the main purpose of these facilities is the provision of long-term care to the elderly and the disabled. At the same time, only a marginal number of patients are being treated in these facilities. Between 2002 and 2014, their number increased from 1,843 to 5,827 (Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü 2015, 8).

To date, none of the facilities run by the market and non-governmental actors focus exclusively on inpatient rehabilitative care. However, I surmise that private long-term care facilities offer rehabilitative care, especially to the disabled and the elderly. More recently, the MoH has taken steps toward increasing the role of market actors in rehabilitative inpatient care. In 2015, the ministry for the first time gave permission for the construction of a private rehabilitation center. The project comprises a large hotel complex with a capacity of 2,500 beds. It needs to be highlighted that the center will be built with the explicit aim of attracting health tourism to Turkey. Hence, it can be assumed that access to medical care will be limited and the focus of the center will be on well-being services (Anadolu Ajansı 2015).¹⁰⁹

Outpatient and rehabilitative day care was provided by a variety of actors prior to the HTP. The MoH ran a network of rehabilitation centers, which accounted for 0.2 percent of total outpatient contacts at all its facilities (World Bank 2003b, 60). In addition, a number of state institutions are also engaged in

¹⁰⁹ According to the state news agency Anadolu Ajansı, four physicians will work at the center.

the provision of outpatient rehabilitative care, including the Ministry of National Defense and the Ministry of Education (*Milli Eğitim Bakanlığı*). Additionally, in 2002, the SHÇEK ran 26 care centers and rehabilitation centers which provided day care (Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü 2015, 7).

In addition, rehabilitative care was provided in outpatient or day care settings by civil society actors, such as the Red Crescent, as well as for-profit actors, such as private polyclinics and practices. Unfortunately, data on the number of these facilities and their healthcare professionals prior to the HTP is not available.

Accordingly, to date, a number of state facilities provide rehabilitative care in outpatient and day care settings. The MoH provides outpatient rehabilitative care in a network of rehabilitation centers as well as at outpatient departments of its hospitals. In addition, university hospitals offer outpatient rehabilitative services. The Ministry of Education provides rehabilitative care in its broad network of Special Education and Rehabilitation Centers. The centers run by the Ministry for Family and Social Policy provide inpatient and outpatient services. Furthermore, the ministry continues to run day care centers, however, their number was reduced to as low as five centers in 2014. Accordingly, the number of patients treated in day care settings decreased from 2,065 in 2002 to 457 in 2014 (Ibid., 8). As I show in Chapter 7, this development can be explained with recent policies aimed at a transition from institutional care to home care.

Data on the number of non-profit and for-profit facilities providing outpatient rehabilitative care is not available. The role of the Red Crescent, which runs a number of rehabilitation centers across Turkey, appears noteworthy. Data on physiotherapists in Turkey suggest that a significant share of rehabilitative service is provided by private actors. In 2013, 1,488 physiotherapists, around a quarter of all physiotherapists, worked in private facilities. In comparison, 1,803 physiotherapists worked in MoH facilities, 403 in university hospitals, 2,555 in facilities owned by the Ministry of Education, 207 in facilities run by the Ministry for Family and Social Policy, and 85 in facilities owned by the Ministry of National Defense (MoH 2014, 92).

As discussed earlier, home care has gained significant importance in Turkey over the last decade. Prior to the HTP, neither the MoH nor the SHÇEK provided rehabilitative home care in a systematic manner. Healthcare professionals working in MoH outpatient facilities were, in theory, obliged to provide medical home care, including rehabilitative services, to patients in their area. However, as I discussed in the previous section, in light of understaffing and limited resources, most facilities lacked the capacities to provide home care.

Since the launch of the HTP, rehabilitative home care has gained significance. According to the Regulation on the Implementation of Family Medicine (*Aile Hekimliği Uygulama Yönetmeliği*) from 2013, family physicians are obliged to coordinate the provision of rehabilitative home care. Furthermore, patients can directly apply for services at a nearby home care coordination center.

Additionally, programs run by the Ministry for Family and Social Policies have set a new focus on home care. The number of disabled people who received home care services provided by the ministry increased from 30,638 in 2007 to 450,031 in 2014 (Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü 2015, 7).

Data on the number of private non-profit and for-profit facilities providing rehabilitative care is not available. Accordingly, it is difficult to assess the market's role. By definition, in contrast to long-term care, rehabilitative care is focused on specific medical goals defined in a rehabilitation plan (OECD et al. 2011, 87). This process commonly involves a trained professional. Given the low number of rehabilitation specialists in Turkey, it can be assumed that market and non-governmental actors provide home care in a limited scope. Likewise, the role of the family must be considered limited in the provision of rehabilitative care. However, it can also be assumed that limited access to professional rehabilitative services increases the importance of long-term care provided by family members.

In sum, the data displayed above shows that the state remains the key provider of rehabilitative care, particularly in inpatient settings. The role of market actors is limited to outpatient rehabilitative care and non-governmental actors and families play a marginal role.

6.3 Long-term care

The SHA 2011 defines long-term care as “a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency” (OECD et al. 2011, 88). It distinguishes between four different categories of long-term care, including (i) medical and nursing care, which is predominantly aimed at the management of symptoms; (ii) personal care services, which provide help with activities of daily living, such as washing and eating; (iii) assistance services in the realm of household management; as well as (iv) other social care services, which predominantly focus on social and leisure purposes (Ibid., 87-88).

Long-term care may be provided by a variety of actors, ranging from health professionals, to community workers and relatives. This makes a clear distinction between healthcare and social care difficult. According to the SHA 2011, the purpose of care defines the boundary, hence, if personal care services are linked to a health condition and based on a medical assessment from a health professional, they are to be considered healthcare. Likewise, if assistance care services, as well as medical and personal care services, are integrated into a package of care services, they fall into the category of healthcare. Long-term care may be provided in inpatient, day care, outpatient, and home care settings (Ibid., 91-92).

The report highlights that cross-national expenditure data suggests access to formal long-term care services provided by health professionals is mostly limited to higher-income countries. In most low- and middle-income countries, long-term services are commonly provided in informal settings, mostly by family members within households. However, it argues that socio-economic changes, such as demographic changes, will lead to a convergent development which comprises a formalization of long-term care (Ibid., 93).

A number of studies have highlighted the chronic underdevelopment of institutional long-term care in Turkey, however, closer scrutiny reveals that despite limited access to professional services, a number of public and private actors are engaged in the field.¹¹⁰

Prior to the HTP, inpatient long-term care was provided in state and university hospitals. In 2000, 31 hospitals specialized in long-term treatment of specific diseases, such as diabetes, cancer, or mental health issues. This number includes the 11 physical therapy and rehabilitation hospitals mentioned in the previous section. These facilities had a capacity of 6,841 beds, which accounted for 4.5 percent of the total bed stock. By 2010, the number of long-term hospitals had increased to 37, with a capacity of 8,469 beds. However, their share of the total bed stock decreased to 4.2 percent (Tatar et al. 2011, 88). It can be assumed that general MoH and university hospitals also provide long-term care. However, as discussed in Chapter 5, there is no data available on the expenses for long-term nursing care in general hospitals. It should be noted that these hospitals resort to their general budgets in order to provide long-term care to patients.

In addition to hospitals, inpatient long-term care was provided to elderly and disabled patients in nursing homes. SHÇEK owned 63 nursing homes with a total capacity of 4,952 beds in 2002 (Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü 2015, 9). Furthermore, as discussed in the previous section, the SHÇEK ran a network of 21 rehabilitation centers that provided long-term care (Ibid., 21). Unfortunately, data on nursing homes run by other state institutions, as well as private facilities, is not available for the years prior to the HTP.

As of 2014, inpatient long-term care for the elderly and disabled outside the hospital setting is provided in 149 Special Care Centers (*özel bakım merkezi*), 85 Care and Rehabilitation Centers (*bakım ve rehabilitasyon merkezi*), and 86 Hope Houses (*umutevi*) owned by the Ministry for Family and Social Policy (Ibid., 7-9). Furthermore, 360 nursing homes with a capacity of 26,222 beds provide long-term care to the elderly (Ibid., 10).

In 2014, the state owned 42.8 percent of nursing homes and 50.8 percent of nursing home beds, while municipalities owned 5.8 percent of nursing homes and 7.8 percent of nursing home beds. For-profit private actors owned 41.9 percent of nursing homes and 29 percent of nursing home beds and non-

¹¹⁰ See for example: Liu et al. 2005; Karabağ 2007; Tatar et al. 2011; Zencir et al. 2005.

profit private actors ran 9.4 percent of nursing homes and 12.3 percent of nursing home beds (Ibid., 10).

A number of institutions provide day care and outpatient long-term care. As discussed, the SHÇEK ran 26 rehabilitation centers, which among other services, provided long-term care to 2,065 elderly or disabled patients in 2002. By 2014, the number of centers had dropped to five and a marginal number of 457 patients received care in these facilities (Ibid., 8). Furthermore, some municipalities, as well as non-governmental and for-profit actors, provide long-term care in day care and outpatient settings to the elderly and disabled. However, data that would allow assessing the scope of these services is not available.

The policy shift from institutional to home-based care, as seen in curative care, is also visible in the realm of long-term care.¹¹¹ This change is being driven by increased access to professional home care services and a reduction in the capacities of facilities providing long-term care in day care settings (Yazıcı 2012; Buğra and Yakut-Çakar 2010). The number of disabled individuals who were treated in home settings through providers attached to the Ministry for Family and Social Policy increased from 30,638 in 2007 to 450,031 in 2014 (Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü 2015, 7).

Despite the significant improvement to home-based long-term care, it can be assumed that most long-term care patients receive care from informal caregivers. In 2014, 268,038 individuals in Turkey were registered with a disability rate of at least 70 percent and 332,432 individuals with a disability rate of between 40 and 69 percent (Ibid., 6). However, the United Nations puts those numbers dramatically higher, estimating that there were some 7.5 million disabled individuals in Turkey in the early 2000s (United Nations Development Group 2000, 69).

It should be noted that we know very little about the mechanisms of healthcare and welfare provision in Turkish households. While informal for-profit care is a visible phenomenon in Turkey, no studies exist that shed light on the role of market actors in informal long-term care. Likewise, we know little about how patients receive care provided by kin, inter-generational, and neighborhood networks.

It can be assumed that the vast majority of long-term care is provided by family members in patients' homes (Tatar et al. 2011, 139). Long-term care patients among the most vulnerable groups are particularly dependent on family assistance. A study on Alzheimer's care in the western province of Denizli found that the primary givers of social care were children and spouses, who spent up to 21 hours a week caring for the patient (Zencir et al. 2005).

¹¹¹ This trend is not only visible in the realm of healthcare but also in other social policies such as child protection services (Yazıcı 2012).

6.4 Medical goods

Medical goods, such as pharmaceutical and therapeutic appliances, are often components of healthcare packages, which are provided within the different healthcare functions described in this chapter. They can be administered during a healthcare contact following prescription by a health professional, or through self-prescription (OECD et al. 2011, 97).

In the Turkish context, retail outlets selling medical goods do not exist and are, instead, provided predominantly through a network of pharmacies. When focusing on ownership criteria, the state's role in the provision of medical goods prior to the HTP was limited to the inpatient care sector. In the early 2000s, only a negligible amount of pharmacists, some 4 percent, worked in state-owned pharmacies at MoH hospitals, and 3 percent at university hospitals. Accordingly, only 4.1 percent of pharmacists worked in SSK hospitals (World Bank 2003b, 96).

During this same period, 86.1 percent of the 22,065 active pharmacists worked in private settings. More than half of the 21,500 private pharmacies that existed in Turkey in the early 2000s were located in the seven largest cities. In addition, physicians working in MoH preventive and curative outpatient care facilities, as well as private polyclinics and practices, had the right to sell medical goods if the nearest pharmacy was more than 10 kilometers away (Ibid., 96).

An analysis of the financing dimension of the Turkish healthcare system has shown that households played a key role in the financing of medical goods prior to the HTP. As I have discussed in Chapter 5.1, 32.9 percent of out-of-pocket payments in 2002 and 2003 were made on medical goods (MoH 2004, 25). Even in inpatient settings, approximately 30 percent of hospital patients had to pay for their own medication even though they should have been entitled to medical goods free of charge (Tatar et al. 2007 1034). Here, Turkey resembled other low- and middle-income countries, in which patients or their relatives have to purchase medical goods themselves (OECD et al. 2011, 97).

Data on the role of households in the provision of medical goods to their members is not available, however, studies on self-medication suggest a strong role of the household. A 2006 study from Ankara shows that 19.1 percent of participants said they self-medicate with antibiotics when sick (İlhan et al. 2009, 1152). In comparison, a similar study found that the percentage of self-medication with antibiotics is lower than 2 percent in the Netherlands, Sweden and the UK but as high as 14.2 percent in Spain (Grigoryan et al. 2006, 452).

In this context, it needs to be stressed that self-medication or medication through non-professionals is made possible through public policies. The state determines to what extent the sick can resort to informal care by regulating the pharmaceutical market. Accordingly, I explore the topic of regulating the consumption of medical goods in the following chapter.

Since the implementation of the HTP, the setting in which medical goods are provided has not significantly changed. In 2013, 27,012 pharmacists were registered in Turkey, of which 91 percent

worked in private settings, 7.7 percent worked in MoH facilities, and 1.1 percent in university hospitals (MoH 2014, 137).

The number of pharmacists per 100,000 citizens has also only marginally increased over the last decade, from 33.6 in 2002 to 35.2 in 2013, less than half the EU average of 74. Regional disparities are also exist; the number of pharmacists per 100,000 inhabitants in eastern Anatolia increased from 16 in 2002 to 20 in 2013. In western Anatolia the number decreased from 48 to 46 over the same period (Ibid., 143).

However, as highlighted earlier, the fact that the vast majority of pharmacies are owned by for-profit actors gives only limited insight into the level of decommodification of access to medical goods. In the following chapter, I show that the state strictly controls the financing of medical goods but, until recently, has only loosely regulated their provision. I also discuss to what degree low level of state regulation enabled households to play such a significant role in healthcare financing and provision.

6.5 Preventive care

The SHA 2011 defines preventive care as a “measure that aims to avoid or reduce the number or the severity of injuries and diseases, their sequel and complications [Pomey et al. 2000]. Prevention is based on a health promotion strategy that involves a process to enable people to improve their health through the control over some of its immediate determinants. This includes a wide range of expected outcomes, which are covered through a diversity of interventions, organized as primary, secondary and tertiary prevention levels” (OECD et al. 2011, 100).¹¹²

According to the Turkish constitution the MoH is responsible for preventive healthcare provision. Prior to the HTP, the ministry met this obligation predominantly through its network of outpatient care facilities, which were responsible for the provision of immunization, family planning, and antenatal services. These were complemented by services provided by other ministries, such as the Ministry of Education, which had also been engaged in preventive care, particularly in environmental health and health education (Tatar et al. 2011, 117-18).

Limited access to and poor quality of services greatly limited their results, in particular in the fields of vaccination and antenatal care. Immunization coverage for basic vaccines such as polio and measles were as low as 70 to 80 percent in 2002 (Ceyhan 2002, 564). Although the child mortality rate in Turkey had dropped steadily over the previous decades, the under-five child mortality rate between

¹¹² In the literature, preventive care and public healthcare are often used as synonyms. The European Observatory on Health System and Policies defines public healthcare as “a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention, and other forms of health intervention (Rechel et al. 2010, 67).

the years 2000 and 2004 was still among the highest in the OECD at 22 deaths per 1,000 live births (WHO online).

Despite the lack of data, it can be assumed that societal actors only played a marginal role in preventive care. Non-profit hospitals located in urban areas may have contributed to public healthcare through vaccinations. These services were financed predominantly out-of-pocket and were, therefore, used mostly by wealthier segments of society. Other societal actors, such as NGOs, may have been involved in health education, however, their overall role prior to the 2000s should be considered marginal. Likewise, the impact of for-profit facilities, such as private hospitals, practices and polyclinics was marginal and limited to the provision of vaccinations. Only 5 percent of children were vaccinated in private facilities before the reforms of the AKP government (Ceyhan 2010, 564).

Since the early 2000s, Turkey has witnessed significant reforms in preventive care provision. A series of WHO programs, such as the Expanded Program for Immunization (*Genişletilmiş Bağışıklama Programı*), aimed at increasing vaccination levels (Kringos et al. 2011). In addition, according to the Family Medicine Law from 2004, the provision of preventive healthcare measures, and in particular the vaccination of children, has become a key responsibility of family physicians, whose performance is closely monitored by the MoH.

When examining more recent data, the outcome of the reforms, which had a strong focus on immunization and prenatal care, is clearly visible. Prior to the reforms, only 14.9 percent of pregnant women consulted a health professional at an outpatient care unit run by the MoH. Some 40 percent of women chose private facilities for antenatal care services, while 34 percent, and almost 50 percent in rural areas, did not consult a health professional during pregnancy (Çelik 2000, 224).

In contrast, a study conducted in 2013 in Bursa showed that 96.3 percent of pregnant women who were in or over a 33-week pregnancy or had given birth had received prenatal care from family physicians (Çatak 2014, 63). Likewise, the average national immunization rate increased from 70 percent in 2003 to 97 percent in 2010 (World Bank 2013, viii).

As discussed earlier in this section, ownership of the majority of the facilities in the network providing preventive and curative outpatient care facilities, remains in the hand of the state. Accordingly, given higher utilization rates, the introduction of the family physician system has resulted in a strengthening of the state's role in preventive care.

Recent data on preventive care provided by market or non-governmental actors is not available. However, the significant increase in utilization rates of the family physician system and the decreasing number of for-profit institutions providing outpatient curative care suggest that they have also lost importance in preventive care. The same may hold true for the role of the family, which prior to the reforms of the HTP, was the key provider of prenatal and antenatal care for a significant number of

women. However, more research is necessary to examine the role of families in healthcare provision to validate this claim.

6.6 Intermediate results: The transformation of healthcare provision

In this chapter, I have analyzed the transformation of healthcare provision in Turkey. Structured by the analytical categories of the SHA 2011, I have examined changes in the respective healthcare functions by focusing on shifts in provider capacities as well as ownership. My aim has been to retrace the transformation of the actor constellation that constitutes the provision dimension of Turkey's healthcare system, and to find further empirical proof of policy changes under the AKP government.

With regard to the overall changes in the number and capacity of providers, I have highlighted the significant increase in the quantity of curative inpatient and outpatient care. Between 2002 and 2013, a total of 361 new hospitals were built (MoH 2014, 71) and the number of physicians increased from 91,949 to 133,775 (ibid., 137). Furthermore, utilization and quality of services has improved significantly. These findings correspond to the results of Chapter 5 and to the overall increase of healthcare expenditures.

I have furthermore examined shifts in the actor constellation in the different healthcare functions prior to and after the AKP reforms. In the following, I categorize the level of these changes based on an analytical framework that elaborates on Wendt et al. (2009). In my concept, (i) a system change occurs when the predominant actor in the respective healthcare function changes; (ii) an internal system implies that while the predominant actor remains constant, complementary providers emerge or lose relevance; (iii) an internal change is defined as a transformation, which leaves the overall actor constellation in place. My findings are summarized in Table 19.

Table 19

The transformation of the actor constellation in healthcare provision

	Key actors (ownership)		Level of change
	2003	2014	
Curative care	State-based	State-based	Internal system change
Inpatient	State, societal, market, family	State, market, family	Internal system change <ul style="list-style-type: none"> - state remains key provider, owning 77.9 percent of hospital beds - nongovernmental actors marginalized - market actors gain momentum. Number of for-profit hospitals almost doubled - family complements professional caregivers
Day care	---	---	---
Outpatient	State, societal, market, family	State-based type	Internal system change <ul style="list-style-type: none"> - state gains momentum through the family physician system - nongovernmental actors marginalized - market actors lose momentum
Home care	Family	Family, state	Internal system change <ul style="list-style-type: none"> - family remains key provider - state gains momentum
Rehabilitative care	State-market mix	State-market mix	Change of levels
Inpatient	State	State	Change of levels <ul style="list-style-type: none"> - state remains key provider - capacities of state-owned institutions decreased
Day care	--	State, market	N.a. <ul style="list-style-type: none"> - capacities of state-owned institutions decreased
Outpatient	--	State, market	N.a. <ul style="list-style-type: none"> - capacities of state-owned institutions decreased
Home care	Market	State, market	Internal system change <ul style="list-style-type: none"> - state gains momentum
Long-term care	Family-based	Family-based	Internal system change
Inpatient	State	State, market	Internal system change <ul style="list-style-type: none"> - rudimentary access to professional care - market has gained momentum
Day care	--	State, market	N.a. <ul style="list-style-type: none"> - rudimentary access to professional care - capacities of state-owned institutions decreased
Outpatient	--	State, market	N.a. <ul style="list-style-type: none"> - rudimentary access to professional care - capacities of state-owned institutions decreased
Home care	Family	Family, state	Change of levels <ul style="list-style-type: none"> - family remains key provider - state has gained momentum
Medical goods	Market-based	Market-based	No changes <ul style="list-style-type: none"> - for-profit pharmacies remain key providers
Preventive care	State-based	State-based	No changes <ul style="list-style-type: none"> - state remains key provider

Source: Own depiction.

The state remains the key provider in inpatient curative care, owning 60.8 percent of hospitals and 77.9 percent of beds. Furthermore, between 2002 and 2013, the MoH built 99 new hospitals and

increased the number of beds by more than 23,500 (MoH 2014, 71). However, my findings point to a significant shift in inpatient curative care with regard to the increasing role of market actors. While prior to the HTP, market actors played a limited role, today, more than one-third of hospitals and one-fifth of hospital beds are owned by for-profit private actors. One out of three inpatient contacts and surgeries occur in private settings. This corresponds to the fact that 279 new private hospitals were built between 2002 and 2013 (Ibid., 145). Furthermore, with the transfer of SSK-owned facilities to the MoH, non-governmental actors have lost their relevance as providers of inpatient care. Only a handful of non-profit hospitals that are owned by foundations provide services to a marginal share of the population. My findings also highlight a specific trait of inpatient care provision in Turkey, namely the *refakatçi* system, where the family serves as a significant actor in inpatient curative care. In sum, the majority of inpatient curative care continues to be provided by a state-based arrangement of actors, however, according to my findings; an internal system change took place.

In outpatient curative care, the state has gained momentum. Prior to the reforms, the network of facilities financed by the government preventive and curative outpatient care scheme, provided a low quality of services to the urban poor and rural population. This has changed significantly with the establishment of the family physician system, which has decreased regional disparities and led to higher utilization of services across the country. My findings suggest that the new role of the state in outpatient curative care was complemented by a decline in market actors. Many of the once highly profitable polyclinics have been closed. Furthermore, with the transfer of SSK facilities to the MoH, the role of non-governmental actors has been marginalized. Thus, while I have detected an internal system change, the provision of outpatient curative care continues to be based on a constellation of state-dominated actors.

The key provider in curative home care has been the family. My findings correspond to the analysis of healthcare expenditure data which suggest that the state did not perceive home care as its responsibility. However, my findings also show that a growing number of patients are being treated at home by state-owned providers, pointing to a significant change in public policy. I examine this new role of the state in home care provision in more detail in the next chapter.

In sum, I have shown that the actor constellation providing curative care in Turkey has been state-based. Since the AKP came to power, an internal system change has occurred and a new actor constellation has emerged. The state holds its position as the predominant actor but the market has gained momentum in inpatient care, and the role of non-governmental actors has been marginalized. At the same time, while the policies have, to a certain degree, removed some of the burden from households, the family remains a key actor in curative care provision. This role is not limited to home care but also manifests in the healthcare mix in state-owned inpatient facilities.

When focusing on the actor constellation in rehabilitative care provision, changes have been less obvious. All institutions that provide inpatient rehabilitative care are owned by the state and while their overall capacity has traditionally been low, it is nevertheless remarkable that the number of hospitals and beds has decreased even further under AKP rule. Lack of data on the numbers and capacity of non-state providers in day care and outpatient care make it impossible to identify any changes. However, my findings show that the capacity of state-owned providers has decreased. Focusing on rehabilitative home care, I found that the state has gained momentum, however, I was not able to detect significant shifts in the state and market-based actor constellation providing rehabilitative care in Turkey.

Long-term care provision has traditionally been marked by the absence of professional actors. The AKP reforms have not changed this picture and the family remains a key provider. These findings correspond to the results of the analysis of healthcare expenditure. However, market-owned private institutions in inpatient long-term care have recently begun to complement state-owned facilities. Furthermore, the state has adopted a new role in long-term home care provision. Between 2007 and 2014, the number of disabled who received medical and social home care by providers attached to the Ministry for Family and Social Policy increased from 30,638 to 450,031 (Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü 2015, 7). My findings allow me to conclude that an internal system change occurred in long-term care.

No relevant changes can be observed in medical care provision. Market-owned pharmacies remain the key actors and the number of providers has remained constant. In preventive care, the introduction of the family physician system has visibly increased provider capacity and reduced regional disparities. However, the state-based actor constellation remains unchanged.

In sum, I have shown that the healthcare provision dimension has undergone significant changes since the AKP came to power. However, I have not found sufficient empirical evidence that would indicate a system change defined as a shift among the predominant actors in any of the respective healthcare functions. Instead, I argue that an internal system change occurred. Based on these findings, I conclude the following:

First, under the AKP government, the state has adopted a new role in healthcare provision. The network of facilities financed by the government preventive and outpatient curative care scheme, as well as the state-owned hospital sector, has been modernized and extended. New outpatient and inpatient care policies have considerably reduced regional disparities. These policies have extended physical access to services, as well as their quality, and have to be seen as complementary to the reforms in healthcare financing which I described in Chapter 5. I argue that in both dimensions, new policies were underpinned by the common goal to create access to universal healthcare for the entire population.

Second, market actors have gained considerable momentum in curative inpatient care. The question is whether this leads to a commodification of healthcare services. As privatization of services does not necessitate their commodification, in the following, I put my findings into context with the transformation of the financing and regulation dimensions. It needs to be emphasized that for-profit healthcare providers had been an integral part of curative care provision prior to the AKP reforms. In the next chapter, I examine how the state regulates those for-profit actors that have gained momentum in recent years.

Third, the new role of the state also manifests in new policies that have established professional home care in Turkey. Prior to the recent reforms, the Turkish healthcare system was marked by the principle that the family is responsible for financing and providing healthcare for its members. The *refakatçi* system and informal out-of-pocket payments in inpatient care settings illustrate how this principle translated into healthcare policies. State and healthcare institutions perceived the family as an integral actor in the healthcare mix. However, the state did little to empower the family in its presumed role.

More recently, we are able to observe a strengthening of the state's role in curative, rehabilitative, and long-term care provided in home-based settings, which at first sight, suggests relief for many households. However, given that access to these services is limited, the family remains the key actor in home care provision. At the same time, the trend from inpatient to home care suggests that family members have no real choice about how they want to integrate care into their lives. However, it needs to be emphasized that inpatient care has remained greatly underdeveloped and only a fraction of the sick were cared for in institutional settings.

In sum, the new policies on home care appear to be based on the principle of subsidiarity and aim to strengthen the capacity of the family to provide healthcare, which would suggest a paradigm shift. In the next chapter, I examine what role policy makers envisage for the family as part of the modernization project of the Turkish healthcare system.

The results of this chapter are crucial for further validating the hypotheses of this thesis and I complement my findings with the following analysis of the regulation dimension of the Turkish healthcare system. Based on my preliminary findings, I come to the following conclusions:

(i) In accordance with the results of Chapter 5, I find that sub-hypothesis 1—that the healthcare reforms of the AKP led to a system change in the actor constellation that constitutes Turkey's healthcare system—is not valid. A shift in the predominant actor constellation has not occurred in any of the healthcare functions; (ii) However, my analysis clearly verifies sub-hypothesis 1.2 that the reforms of the AKP strengthen the role of market actors as providers in Turkey's healthcare system; (iii) Furthermore, I find that they decrease the role of the family in healthcare provision, which combined with the results of the previous chapter, validates sub-hypothesis 1.4; (iv) I have presented additional empirical proof that validates sub-hypothesis 2 and sub-hypothesis 2.1 that the healthcare

reforms of the AKP lead to a paradigm shift in healthcare policy and changing policy goals; (v) Lastly, my findings further substantiate the argument that the reforms of the AKP lead to the emergence of a mature welfare state, which protects its citizens from risks related to sickness on the basis of social rights and, accordingly, validate sub-hypothesis 2.2. Elaborating on these results, I examine in the following chapter how the state has regulated the roles of market and non-governmental actors, as well as the family in healthcare financing and provision.

7. The transformation of healthcare regulation

In this chapter, I analyze the transformation of the regulation dimension of the Turkish healthcare system. In order to achieve this, it is useful to recall my findings on its historical development. In contrast to the paths of modernization of the mature welfare states in western and northern Europe, the central state's engagement in healthcare in Turkey was part of a top-down nation-building process. Due to the lack of structural pressures and limited power resources of social groups, a healthcare system emerged in which the state failed to protect its citizens on the basis of social rights, and governed healthcare institutions through command and control.

My preliminary findings suggest that this picture has now changed and point toward a paradigm shift in healthcare policy. In the following, I examine whether the advent of a new policy goal was matched by a new actor constellation in healthcare governance and by the adoption of less hierarchical policy instruments.

Based on Wendt et al. and the SHA 2011, I examine the actor constellation in healthcare regulation on three levels: (i) The relationship between financing agents and patients; (ii) the relationship between financing agents and providers; and (iii) the relationship between patients and providers (Wendt et al. 2009, 79-81). Accordingly, I analyze which actor dominated these relationships in the respective healthcare financing schemes prior to and since the implementation of the HTP.

Wendt et al. distinguish between three main forms of governance: state-led, corporate-governed, and market-driven. Given the remarkable importance of the family in healthcare financing, as my preceding findings highlight, I add intra-collective governance to these three main forms and examine under which conditions healthcare financing and provision are regulated by the family.

No sector in society, however, is organized by only a single mode of interaction. The market is not based solely on negotiation, while the state does not exclusively govern through hierarchical intervention. Furthermore, the state takes a prominent position in the regulation dimension as it sets the framework that determines the role of non-governmental actors. Accordingly, market-driven forms of governance are framed by executive and legislative decisions and occur in "the shadow of hierarchy" (Hertier and Eckert 2008). Likewise, state policies determine, to a significant degree, the level at which an individual's role in society is determined by his or her position in the market or family.

In the following, I examine whether the Turkish state still interferes in healthcare by means of a hierarchical process or if new forms of governance have emerged that emphasize cooperation between governmental and non-governmental actors. I, therefore, analyze which of the instruments summarized in Table 20 have been used to achieve the policy goals that underpin the respective healthcare financing schemes.

Table 20

Overview of policy instruments

Type of instrument	Impact mechanism	Examples
Ownership, state services and benefits	Redistribution of resources and provision of services	Healthcare financing through taxes and state provision
Legislation and institutional control	Hierarchical steering, command and control	Laws and decrees, filling of positions in decision-making bodies
Financial incentives and agreements	Influencing decision-making through costs	Penalties, benefits, taxes, tax-reductions, individual contracts
Information and communication	Influencing decision-making through knowledge, arguments and normative pressure	Campaigns
Standards and best practices	Determination of processes	Healthcare standards, check-lists

Source: Own depiction based on Willert 2011; Le Gales 2011.

7.1 Regulation of the relationship between financing agents and patients

In this section, I analyze the regulation of the relationship between financing agents and patients within the different healthcare financing schemes prior to and since the implementation of the HTP. The analytical categories of the SHA 2011 offer a suitable framework to investigate these relationships. As shown in Chapter 5, the constellation of financing agents, access criteria, and mix of revenues differ significantly across the different schemes. The distinction between financing schemes and financing agents makes it possible to analyze the regulatory role of the state, the market, and non-governmental actors within the schemes under discussion. Furthermore, as the SHA 2011 considers households as financing agents, it is possible to examine how public policies address the role of the family in healthcare financing and to what degree patients' access to healthcare is regulated by households (OECD et al. 2011, 178-79).

My analysis focuses on three questions. In terms of changes in the actor constellation, I examine (i) who decides which groups in society are covered by the respective scheme and (ii) who regulates the respective scheme's system of financing by determining their mixtures of revenues (Wendt et al. 2009, 80).¹¹³ In order to examine policy change, I explore (iii) which instruments the state has used to regulate the relationship between financing agents and patients (Hall 1993).

¹¹³ Wendt et al. suggest that two dimensions are essential for the analysis of the relationship between financing agencies and beneficiaries. First, the mode of coverage of healthcare systems and the ways parts of the population are included in public or private healthcare systems. Second, the system of financing in which they broadly distinguish between public financing, i.e. taxes and social insurance contributions, and private funding, i.e. private insurance contributions and out-of-pocket payments (Wendt et al. 2009).

7.1.1 Regulation of the relationship between financing agents and patients prior to the HTP

The key financing agent of the government preventive and outpatient curative care scheme was the MoH, with households acting as complementary financing agents. The mode of coverage of the scheme was regulated through legislation in the Socialization of Health Services Law. According to Article 2 of the law, all Turkish citizens had the right to free access to healthcare provided by the state. Accordingly, the scheme's mode of coverage was regulated by state institutions, namely the Grand National Assembly as the ultimate legislative authority, and the MoH as the institution responsible for implementing healthcare policies.

The scheme was financed foremost by taxes. However, to secure additional revenue, the state allowed the establishment of revolving funds, which collected copayments from the social insurance agencies. Fees-for-services were negotiated between the MoH and the insurance agencies and determined in individual protocols signed by both parties.¹¹⁴ Revolving funds were kept and managed by the MoH's Provincial Health Directorate (World Bank 2003a, 55).

While state institutions regulated the scheme's revenues from taxes, and copayments from social insurance agencies, the exclusion of medical goods from the benefits catalog integrated households into the scheme as financing agents. At the same time, the state failed to implement regulations that would prohibit providers from charging informal copayments. In consequence, patients depended on their families' capacity and willingness to allocate household revenues to finance medical care and services.

In sum, the state was the key regulator of the relationship between financing agents and patients in the government preventive and outpatient curative care scheme. It decided which groups were covered by the scheme and regulated its system of financing. However, high out-of-pocket payments, and in particular, the exclusion of medical goods from the scheme's benefits catalog, resulted in a significant level of intra-collective regulation. The regulatory role of the family in the scheme undermined the scheme's principle of free access to care based on citizenship. These findings further validate the claim that the main policy goal behind the scheme was to provide only rudimentary care to vulnerable groups in society. At the same time, policy makers considered the family responsible for the healthcare of its individual members. The key policy instruments used by the state to regulate the relationship between financing agents and patients were ownership and legislation. In addition, agreements with social insurance agencies were used to gain access to additional sources of revenue. The key financing agent of the government scheme for the poor was the MoH, with households acting as complementary financing agents. The scheme's mode of coverage was determined in Articles 3 and 4 of the Law Concerning State Coverage of Treatment Expenses of Citizens Who Lack the Ability to Pay

¹¹⁴ In practice, this shifted the financial burden from the budget of the MoH to the treasury, which had to balance the deficits of debt-ridden social insurance agencies.

by Issuing a Green Card from 1992. Entitlement was based on a means test which assessed the income of entire households. However, as medical goods were excluded from the benefits catalog, households regulated access to medical goods intra-collectively.

With regard to state-family relations, the means test used for entitlement is noteworthy. Applications were handled by state-owned Green Card service centers and based on a mixture of centrally determined criteria and individual assessment by local authorities. In a first step, it was determined if the applicant was registered with any of the social insurance schemes or if they owned a motor vehicle. A Green Card was not issued if either of these were the case. In a second step, the average income of the household was estimated based on reported incomes, and in a third and final step, a local committee which, included members of civil society, decided if the household should be admitted into the program (Aran and Hentschel 2012, 4-5).

The assessment of households as collectives and the entitlement of kin are remarkable features of the scheme. Entitlement criteria show that, in addition to the goal of allowing vulnerable groups in society access to rudimentary care, related policies were underpinned by the goal of strengthening the family's capacity to finance and provide healthcare to its individual members. In consequence, an individual's access to services depended on his or her position in the family and on cohabitation. Therefore, the policy strengthened and reproduced the role of the extended family in welfare provision.

The system of financing the scheme was also determined by law. In the early 2000s, the vast majority of the scheme's revenues came from the general budget allocated by the MoF to the MoH. The scheme's budget was determined on an annual basis and the MoH was accountable to the MoF. Funds were distributed by the MoH's Provincial Health Directorates to the individual facilities (World Bank 2003b, 122). Accordingly, legislation was the key policy instrument that regulated the relationship between financing agents and patients within the scheme.

In sum, in the government scheme for the poor, the state was the key regulator of the relationship between financing agents and patients. The main policy instrument was legislation. Complementary to the state, families intra-collectively regulated access to services and medical goods. While the main policy goal of the scheme was to provide rudimentary care to the poor, entitlement policies were underpinned by the premise that the family as a social and economic unit is responsible for the healthcare of its members. Given the rise of urban poverty in the 1980s and 1990s, the policy aimed to strengthen the family's capacity to fulfill this role.

The key financing agent in the government employee schemes for active civil servants was the MoF, which in practice also administered the scheme. The mode of coverage was determined by state institutions under the Civil Servants Law from 1965. Regulations on civil servants' dependents, who were also covered by the scheme, were striking. Insurants' parents were granted dependency status if

they were not covered by any government or social insurance schemes (Article 188). Furthermore, the spouse of the civil servant; male children up to the ages of 18, 20, or 25, depending on their enrollment in higher education; unmarried daughters; and disabled children were also covered by the scheme (Article 206).

The broad definition of dependency status and, in particular, the extensive coverage of daughters and disabled children further highlight that healthcare policies were underpinned by the notion that the family as an economic and social collective is responsible for its members' healthcare and welfare. The state acknowledged this role and supported families by granting generous access to healthcare. However, the policy increased the dependency of individuals on the family when sick and reproduced gender roles (Grütjen 2008; Kılıç 2008).

The scheme was predominantly financed through taxes. Hence, the parliament, which approved the annual central budget, and the MoF regulated its system of financing including copayments. Households contributed to the scheme's revenues in the form of formal and informal copayments. As the quality of services was high and the scheme financed the majority of the costs for medical goods, the level of intra-collective regulation can be considered marginal. Accordingly, legislation was the main policy instrument regulating the relationship between financing agents and patients within the scheme.

In sum, the relationship between financing agents and patients in the government scheme for active civil servants was predominantly regulated by state institutions through legislation. In contrast to the Green Card scheme, the family played a limited regulatory role. However, dependency regulations show that the policies behind the scheme were based on the premise that the family is responsible for the welfare and healthcare of its members. Accordingly, the scheme's primary policy goal to compensate specific occupational groups for risks and costs related to illness was complemented by the goal of strengthening the family's capacity in healthcare financing.

The *Emekli Sandığı* was the key financing agent of the government employee scheme for retired civil servants and their dependents. The mode of coverage of the scheme was defined by Article 67 of the Law on the Retirement Fund of the Turkish Republic from 1949. Dependency regulations matched those of the government employee scheme for active civil servants. However, state regulation over the *Emekli Sandığı* went beyond legislation. Article 1 determined that the *Emekli Sandığı* was a legal entity subordinate to the MoF. Its main decision making body, the board of directors (*yönetim kurulu*), was dominated by government representatives. Four of the seven members of the board were chosen by the Prime Ministry (*Başbakanlık*) and the MoF. Furthermore, the MoF had to approve major decisions made by the board (Article 3).

The scheme's system of finance was determined by the MoF. As I have discussed in Chapter 5.2, the healthcare branch of the *Emekli Sandığı* was exclusively financed through revenues from the MoF. In

congruence to the government scheme for active civil servants, the level of intra-collective regulation through families can be considered limited.

In sum, in the government employee scheme for retired civil servants the relationship between financing agents and patients was regulated by the state. State institutions determined which groups were covered by the scheme and its mixture of revenues. The main policy instruments were legislation and institutional control over the key financing agent, *Emekli Sandığı*. The policies that determined dependency regulations aimed to strengthen the capacity of the family in healthcare financing.

The mode of coverage of the social health insurance scheme, which was administered by its key financing agent, SSK, was defined by the Social Insurance Law from 1964. Dependency regulations matched the regulations of the government employee schemes and aimed at strengthening the capacity of the family (Articles 35 and 42).

The scheme's system of finance was regulated foremost by the state. Insurance premiums were defined by the Ministry of Labor and Social Security and levels of the SSK copayments to revolving funds were determined by the MoH and the MoF. Households contributed to the scheme's revenues in the form of formal copayments for medical goods, which were determined by law (Ibid.). In congruence to the government employee schemes, households played a rather limited role as regulators of the relationship between financing agents and patients. The MoF contributed to the financing of the scheme by balancing its deficits (OECD and World Bank 2008, 112).

According to the Labor Insurance Institution Law from 1945, the SSK was a legal personality subject to private law, which was subordinate to the Ministry of Labor and Social Security, but financially and administratively autonomous. However, in comparison to social insurance agencies in mature corporatist welfare states, the level of state control over the SSK's decision-making bodies was extraordinary. According to regulations in the early 2000s, the general and deputy directors were nominated by the Minister for Labor and Social Security and most of the members of the SSK's executive organs were, likewise, selected by state ministries. The board of directors (*yönetim kurulu*), its main decision making body, was composed of a total of six members. Employer associations or labor unions were represented by one member each. The other four members were the SSK director and representatives from state ministries (Article 10).

In sum, the state strictly controlled the relationship between financing agents and patients in the scheme administered by the SSK. Access criteria and the scheme's system of financing were determined by state institutions. The main policy instrument was legislation. Furthermore, the state exerted a high level of institutional control over the SSK.

The key financing agent of the social insurance scheme for the self-employed was the *Bağ-Kur*. The scheme's mode of coverage was regulated by the Regulation on *Bağ-Kur* Health Insurance Assistance (*Bağ-Kur Sağlık Sigortası Yardımları Yönetmeliği*) from 1986. Dependency regulations were identical to

those of the *Emekli Sandığı* and the SSK, and aimed at strengthening the capacity of the family in healthcare financing (Article 5).

The scheme's system of finance was determined by state institutions. It was financed through insurance premiums determined by law and by transfers from the central budget. Households contributed to the scheme by financing copayments for medical goods, which were likewise determined by law. Remarkably, according to Article 9, insurants had to contribute to the scheme for up to eight months before benefit entitlement. Moreover, insurants with premium debt were excluded from coverage.

Legislation was the main policy instrument used to regulate the relationship between the *Bağ-Kur* and patients. In addition, similar to the SSK and the *Emekli Sandığı*, the state had a high level of institutional control over the *Bağ-Kur*. According to the Law on the Social Insurance Institution for Tradesmen and Craftsmen and Other Self-Employed Workers, the agency was subordinate to the Ministry of Labor and Social Security but financially and administratively autonomous. Its director and deputy directors were nominated by the government based on the recommendations of the ministry. Likewise, in addition to the agency's director, two of the four members of the board of directors (*yönetim kurulu*) were representatives of state ministries (Article 8).

In sum, in the scheme administered by the *Bağ-Kur*, the state regulated the relationship between the financing agent and patients by determining the mode of coverage and the system of financing. The main policy instrument was legislation. Furthermore, the state had a high level of institutional control over the decision making bodies of the *Bağ-Kur*. In general, households played a limited regulatory role in the scheme. However, insurants depended on household schemes during the waiting period before enrollment and often fell into premium debt.

In contrast to the government and social insurance schemes, the state exerted only limited control over voluntary health insurance schemes. For-profit insurance agencies administered the schemes in practice and were free to determine access criteria and contribution rates. The state's role was, therefore, limited to setting the legislative framework to establish voluntary health insurance schemes. My research does not uncover any policies that strengthened voluntary health insurance schemes, such as subsidiaries or tax cuts for insurance companies or for insurants. However, as I have shown in Chapter 5.2, voluntary health insurance schemes were supplementary and insurants could not drop out of government employee and social insurance schemes.

Household schemes are characterized by a voluntary mode of participation. Funds are pooled by an individual household and the purchase of services depends on its ability or willingness to pay. At current state, we know very little about the mechanisms that allow families in Turkey to finance and provide healthcare. More research is necessary to examine the importance of gender relations, the

explicit role of the nuclear and extended family, as well as support mechanisms across generations and households.

However, in the previous chapters, I have discussed a number of policies that have shaped and reproduced the importance of the family in healthcare, such as the exclusion of roughly one-third of the population from the government and social insurance schemes; the underdevelopment of long-term care provision; the exclusion of medical goods from benefits packages; long waiting periods for SSK and *Bağ-Kur* insureds before entitlement and entitlement loss for *Bağ-Kur* insureds with debt; the permission for state-employed physicians to earn auxiliary incomes in private settings; etc. These policies significantly contributed to the importance of household schemes and the high level of intra-collective regulation in the Turkish healthcare system.

In sum, prior to the HTP, the relationship between financing agents and patients within the various government and social insurance schemes was regulated foremost by the state. Modes of coverage and the systems of financing of the respective schemes were determined by state institutions. The predominant mode of governance was marked by hierarchical steering. Accordingly, the main policy instruments were ownership or legislation. Only in exceptional cases, non-hierarchical policy instruments, such as agreements, were used.

My findings moreover show that the high level of state control over the social insurance agencies sets the Turkish healthcare system apart from the classic representatives of the Social Insurance Model. In the latter, highly autonomous interest groups and social insurance agencies are the key decision makers, while the state's primary role is to establish a regulatory framework which allows bargaining among these actors. In Turkey, such bargaining between autonomous non-governmental actors did not take place. Instead, state representatives dominated the executive organs of the social insurance agencies and strictly regulated the relationship between financing agents and patients through legislation (see also Wendt et al. 2013).

In contrast, the state exerted only very limited control over voluntary health insurance schemes. Market actors, thus, dominated the relationship between financing agents and patients. However, given the limited coverage of these schemes, the overall regulatory role of the market in the regulation of the relationship between financing agents and patients was marginal.

The regulatory role of households prior to the HTP varied across the schemes. Particularly in the government scheme for preventive and curative outpatient care and the government scheme for the poor, families had a strong regulatory impact on the coverage and the mix of revenues of the schemes. Access to services financed by these schemes significantly depended on the willingness and capacity of the beneficiary's family to finance care. In contrast, the level of intra-collective regulation in government employee schemes and the social insurance schemes was limited.

7.1.2 Regulation of the relationship between financing agents and patients since the HTP

The role of the state as the key regulator of the relationship between financing agents and patients was strengthened even further with the reform of the government preventive and outpatient curative care scheme. Since the full implementation of the family physician system in December 2010, the scheme's mode of coverage and system of finance have been determined by the Family Medicine Law from 2004. According to Article 3, the MoH remains the key financing agent for personnel salaries and facility running costs. The level of intra-collective regulation has decreased significantly since households no longer function as complementary financing agents. Furthermore, the scheme is no longer financed by copayments from social insurance agencies and, accordingly, the MoH no longer signs agreements with social insurance funds. The main policy instruments, therefore, are currently ownership and legislation.

The establishment of the SGK has had a significant impact on the regulation of the relationship of financing agents and patients in current government and social insurance schemes. The MoH has lost its role as a purchaser of services and the SGK has become the key financing agent.

According to Article 1 of the Social Security Institution Law from 2006, the SGK is a public legal body with legal personality, and while subordinate to the Ministry of Labor and Social Security, it retains financial and administrative autonomy. About 99 percent of the SGK's employees are civil servants (SGK 2014). The SGK implements and improves social policies, informs natural and legal persons for whom it serves, and is responsible for the coordination of international cooperation in the realm of social policy (Article 3).

The SGK's main decision-making body, the 12-member board of directors (*yönetim kurulu*), is staffed with representatives from various institutions: four SGK representatives; one member each from the Ministry of Labor and Social Security and the Treasury, one member from an employer associations; and five representatives from different labor unions (Article 6). Accordingly, in comparison to the SSK, the share of board members representing non-governmental institutions has visibly increased. Coverage and systems of financing of the numerous schemes are determined in the Social Security and General Health Insurance Law from 2006.

The HTP also brought changes to the regulations for insurants' dependents. Prior to the reform, unmarried, as well as divorced daughters were covered by their parent's health insurance as dependents. While this policy secured the healthcare of women in case of unemployment or divorce, it also increased the dependence of women on the family and reproduced the predominant male breadwinner model (Kılıç 2008, 493). At the same time, it granted many female workers in the informal sector access to the healthcare system. Given the importance of informal employment in the Turkish economy, dependency regulations also helped to reproduce the Turkish model of capitalism that relied largely on informal labor (Özar and Yakut-Çakar 2012, 1).

Under Article 3 of the Social Security and General Health Insurance Law, unmarried children under the ages of 18, 20, or 25, depending on their enrollment in higher education, as well as spouses, are considered dependents. Furthermore, disabled children and parents whose livelihoods are financed by the insurance holder fall into this category. Accordingly, the reform eliminated gender-based inequalities in the dependency regulations governing male and female children. The new dependency regulations are now in force across all the schemes (see also Kılıç 2008). In the following, I discuss the impact of the AKP reforms on the individual schemes administered by the SGK.

With the reform of the government scheme for the poor, the MoH lost its role to the SGK as the key financing agent. Furthermore, households no longer function as complementary financing agents. However, the state remains the key regulator of the relationship between financing agents and patients. The importance of intra-collective regulation has decreased since households are no longer the primary financers of medical goods.

Accordingly, although ownership has become irrelevant, the state continuously resorts to a hierarchical mode of governance to regulate the relationship between financing agents and patients. The scheme's mode of coverage and its system of finance are regulated by law. Furthermore, the state still plays an important role in the decision-making bodies of the SGK.

The reform of the government scheme for the poor also introduced a major change in the policies determining entitlement to the scheme. A new means test that was introduced in 2011 no longer assesses the income of the entire household. Instead, only the incomes of household members who belong to the applicant's nuclear family are taken into account. The new means test, therefore, complies with the dependency regulations of the government employee and social insurance schemes and defines the nuclear family as spouse, children, and parents.¹¹⁵

The wording of the legislation highlights the strong underpinning of the male breadwinner model. In theory, any member of a household can apply for benefits, however, the law does not address the individual applicant but the (male) breadwinner of an ideal type nuclear family. Article 10 of the regulation states that "income is determined on the basis of a family living in the same house and comprising a spouse, unmarried children, a grandmother and grandfather".¹¹⁶ However, in practice, if an adult cohabiting with his or her parents takes the means test on behalf of the entire household, the income of any adult, unmarried siblings in the same household is also taken into account. Such a constellation, although highly probable, is not mentioned by the law. It needs to be emphasized that the income of the entire nuclear family is being assessed, regardless of the insurance status of the

¹¹⁵ According to the Regulation Regarding the Procedures and Principles Related to Revenue Assessment, Registration and Monitoring Processes within the Scope of General Health Insurance from 2012, multiple means tests have to be taken if more than one nuclear family lives in the same household.

¹¹⁶ The Turkish original is "Gelir tespitinde, aynı hane içinde yaşayan eş, evli olmayan çocuk, büyük ana ve büyük babadan oluşan aile esas alınır".

respective members. Furthermore, it should be highlighted that the law does not clearly define entitlement for households that host more than three generations.

Similar to the procedures necessary to obtain a Green Card, applicants are entitled to the government scheme for the poor if the average per capita income of the household is below one-third of the minimum wage. Eligibility is reassessed on an annual basis. The means test assesses household composition, income, property, social insurance, and health status, as well as the level of education of the individual household members.

In contrast to the Green Card scheme, the information given by the applicant is evaluated by the SGK. Committees composed of representatives from local authorities were abolished, however, they may still be engaged in the application process through household visits (Erus et al. 2015, 101). While recent data on the number of rejected applicants is not available, household data from 2007 suggests that income and property are the main reasons for being denied entitlement to the scheme (Ibid., 105).

In sum, the reform of the government scheme for the poor has not altered the predominant role of the state in the regulation of the relationship between the financing agent and the patient. The scheme's mode of coverage and system of finance are determined by legislation. New entitlement criteria point toward a legal specification of the family unit and shift social responsibility from the extended to the nuclear family. It needs to be emphasized that the new test under the Social Assistance Information System not only determines access to healthcare but also to a number of state programs, such as scholarships, social homecare for the elderly, conditional cash transfers, and disabled benefits (Menon et al. 2013, 9). The new policy, therefore, further institutionalizes the family's role in the Turkish welfare system.

The relationship between financing agents and patients in the compulsory social insurance scheme is regulated foremost by the state, which determines the modes of coverage and system of financing according to the Regulation Regarding the Procedures and Principles Related to Revenue Assessment, Registration and Monitoring Processes within the Scope of General Health Insurance (*Genel Sağlık Sigortası Kapsamında Gelir Tespiti, Tescil ve İzleme Sürecine İlişkin Usul ve Esaslar Hakkında Yönetmelik*) from 2011. The new means test is also used to determine entitlement to the scheme. All legal residents without social insurance and who live in households that do not fulfill the entitlement criteria for the government scheme for the poor have to contribute to the scheme.

The introduction of the compulsory social insurance scheme and the reform of dependency regulation have had a significant impact on dependents of the old government employee and social insurance schemes, particularly unmarried women. Prior to the reform, the financial burden of unemployed women's social insurance premiums was pooled by the respective government or insurance scheme. Since the introduction of the compulsory social insurance scheme this burden has shifted toward the

household. As employment rates among women are low and most Turks cohabit with their parents until marriage, the new policy has increased the risk of unmarried and divorced women losing access to healthcare (Özar and Yakut-Çakar 2012).¹¹⁷

One of the key drivers of the HTP was the financial unsustainability of the Turkish healthcare system. With the introduction of General Health Insurance, the government aimed to “organize, fund and provide healthcare services in an effective, efficient and equitable manner” (MoH 2012, 8). To date, the significant increase in coverage of the scheme through the integration of poor segments of society has been predominantly financed through state resources. This suggests that policy makers, in accordance with the principle of subsidiarity, aim to extend the family’s role as a financing institution within the scheme. The new policy, moreover, illustrates how the state increasingly regulates the role of the family in healthcare financing.

However, Article 6 of the Social Security and General Health Insurance Law exempts unpaid workers in family businesses from premiums. Insurants’ self-employed spouses who work free of charge in the family business, and up to third degree family members, who work in domestic settings, are not obliged to contribute to health insurance. This loophole favors the many households in Turkey that have income from small family businesses. At the same time, it further institutionalizes the male breadwinner model and reproduces the role of women as unpaid workers in domestic settings or family-owned companies.

In sum, the relationship between financing agents and patients within the compulsory social insurance scheme is regulated by the state which determines the modes of coverage and system of financing. The reforms significantly increase the responsibility of the nuclear family for financing the healthcare of its individual members. Entitlement policies have, moreover, further institutionalized the role of the family in the Turkish welfare system. The policies stand, yet, exemplary for a stricter state regulation of the family’s role in healthcare financing.

Modes of coverage and financing systems of the government employee and social insurance schemes administered by the SGK are regulated by state institutions through legislation. The Social Security and General Health Insurance Law regulates the level of premiums of the various schemes as well as the level of copayments. In the government employee schemes, the MoH has lost its role to the SGK as the key financing agent. However, the state remains the regulator of the relationship between the SGK

¹¹⁷ In 2012, only 28.7 percent of women were in formal employment as opposed to the OECD average of 57.2 percent. In the same year, Turkish women on average married at the age of 23.5. In 2011, the crude divorce rate was 1.6 (UNECE Statistical Database 2016). While the average age of marriage and crude divorce rates are low in comparison to Western European countries, both have increased steadily over the last few decades (Duben 2013).

and patients. The main instrument regulating this relationship is legislation. Furthermore, strong state representation in the agency's decision-making bodies is noteworthy.

The AKP government has implemented a number of legislative changes regarding voluntary health insurance schemes. In 2007, the new Insurance Law (*Sigortacılık Kanunu*) was passed which reformed the legal framework for the establishment and management of private insurance companies. However, the level of state control over the relationship between financing agents and patients remains very limited. Article 12 states that private insurance companies can determine premiums and benefits catalogs.

The Law on Social Security and General Health Insurance lays the groundwork for a stronger role of private health insurance schemes in healthcare financing. Article 98 of the law determines that, based on the recommendation of the SGK, the Undersecretariat of the Treasury at the Turkish Prime Ministry can allow private insurance companies to offer insurance plans which complement the benefits catalogs of the schemes administered by the SGK. In 2012 the SGK published a circular which authorizes private health insurance companies to offer complementary health insurance. Prior to this reform, private companies offered only full health insurance. With the new regulation, private insurance schemes can offer products that explicitly cover: (i) services which are not part of the SGK's benefits catalog; (ii) copayments; and (iii) hotel costs charged by private hospitals (SGK 2015).

Critics claim that the reform effectively encourages a flight of wealthier citizens from state-owned to for-profit providers. They argue that state subsidies and insurance premiums contribute to the financing of a two-class healthcare system, as private providers are cofinanced by the SGK (Yılmaz 2013). At the same time, the reform may lead to a shift in financing and risk pooling from households to voluntary health insurance schemes.

In sum, with the reforms of the HTP, the state has further increased the market for voluntary insurance schemes. At current state, the state exerts limited control over for-profit health insurance companies, which determine access criteria and the systems of finance of the respective schemes. Accordingly, the regulation of the relationship between financing schemes and patients within voluntary healthcare schemes continues to be market-driven. More recent policies point to a stronger desire by the state to regulate the role of market actors and to integrate voluntary insurance funds as financing institutions of SGK insurant services. However, this development needs further research.

In terms of the regulation of the relationship between financing agents and patients, household schemes have lost importance and the number of people who rely solely on household schemes has decreased significantly. Furthermore, a number of services that were exclusively financed through household schemes, such as long-term and rehabilitative care in home-based settings, are now partly financed by the SGK. Accordingly, the family has lost significance in the regulation dimension of the Turkish healthcare system.

Despite the reforms of the HTP, certain groups in society, such as the uninsured and those with premium debt, continue to rely on household schemes when sick. Furthermore, providers continue to charge informal copayments (Kringos et al. 2011, 12). My findings indicate that policymakers regulate the role of the family as a financing institution more strictly. In particular, the reform of dependency regulations combined with the establishment of a new compulsory insurance scheme has shifted the risk pooling away from the social insurance schemes toward individual households.

In sum, with the implementation of the HTP, the role of the Turkish state as the key regulator of the relationship between financing agents and patients in the government scheme for preventive and curative outpatient care, and the various schemes administered by the SGK, has not changed. The state strictly regulates the modes of coverage and systems of financing of the respective schemes.

Furthermore, the traditional mode of command and control governance has not changed. While the introduction of a purchaser and provider split in the SGK administered schemes has caused ownership to lose relevance as a policy instrument, the relationship between financing agents and patients is regulated foremost by legislation.

My research also reveals a significant trait of healthcare governance in Turkey. Unlike the social insurance systems in mature corporatist welfare states, the state exerts extraordinary institutional control over the social insurance agencies by filling key positions in decision-making bodies with state representatives. This remarkable mechanism of state control over a formally autonomous non-governmental actor persists in the governance structure of the SGK. Accordingly, I argue that with regard to the role of the state in the regulation of the relationship between financing agent and patients, the reforms of the AKP government have been path-dependent.

In consequence, although the SGK is the key financing agent in the respective schemes, the regulatory role of non-governmental actors is limited. Likewise, the role of market actors is limited to voluntary insurance schemes which cover only a marginal section of society. However, recent policies indicate that the state aims to further integrate market actors into the financing of the schemes administered by the SGK in the future.

The family has lost significant importance as a regulator of the relationship between financing agents and patients, however, its role has not entirely diminished. Some segments in society continue to depend on household schemes in order to access healthcare. The fact that insureds with premium debt lose their right to access healthcare is noteworthy, as it appears to undermine the primary policy goal of the HTP reforms to create access to universal healthcare for the entire population.

Furthermore, with the HTP reforms, the state has extended its regulatory control over the family in healthcare financing. The institutionalization of the nuclear family as a financing institution in the compulsory social insurance scheme, in particular, represents a significant shift in the transformation of the regulation dimension of the Turkish healthcare system.

7.2 Regulation of the relationship between financing agents and providers

In this section, I analyze changes in the regulation of the relationship between financing agents and service providers within the different financing schemes. As I have shown in the historical analysis, the state has exerted a high level of hierarchical control over providers owned by the state and non-governmental actors since the inception of modern healthcare institutions in the late Ottoman Empire. In contrast, the level of state control over market-owned institutions, which gained momentum in the 1990s, was limited. In order to paint a more comprehensive picture, I examine in greater detail the roles of the state, the market, non-governmental actors, and the family in the regulation of the relationship between financing agents and service providers in the various schemes prior to and since the HTP.

Elaborating on the analytical framework developed by Wendt et al., I examine (i) who regulates access for providers to the respective healthcare financing schemes and (ii) who regulates the remuneration of service providers and the specific system of provider compensation within the respective schemes (Wendt et al. 2009, 80) Furthermore, (iii) I analyze whether the policy instruments that are used by the state to regulate the relationship between financing agents and service providers have changed (Hall 1993).

7.2.1 Regulation of the relationship between financing agents and providers prior to the HTP

The government preventive and outpatient curative care scheme exclusively financed services that were provided by facilities owned by the MoH. Accordingly, the ministry functioned as the key financing agent as well as the owner of service providers. According to the Socialization of Health Services Law of 1961, the ministry was responsible for the establishment, staffing, and management of facilities. Individual healthcare professionals were assigned to their post by the MoH. Many doctors, especially those working in remote areas, were university graduates serving two years of compulsory public service (World Bank 2003a, 12).

The state also regulated the remuneration of service providers. According to Article 2 of the law, professionals who worked in MoH outpatient care facilities were civil servants and worked on a salary basis. As discussed in Chapter 5.2.1, the budget of the scheme and the salaries of civil servants were determined in the central state's annual budget and the MoH was accountable to the MoF for its implementation. Funds for individual facilities were distributed from the MoH's budget to the facilities by the ministry's Provincial Health Directorate (Article 30; World Bank 2003b, 55).

Given the low salaries of health professionals and the dramatic underfunding of the scheme, providers often raised informal copayments from households. In consequence, the family became a

complementary financing agent of the scheme. I surmise that the problem of informal copayments was well known to policymakers in Ankara, however, the state did little to regulate the relationship between households as financing agents and service providers, which in consequence, was predominantly market-driven (Tatar et al. 2007).

In sum, in the government preventive and outpatient curative care scheme, services were provided exclusively by the state, which also predominantly financed them. Accordingly, the MoH was the key regulator of the relationship between financing agents and patients. The ministry determined the access of providers to the scheme as well as their remuneration. However, the state exerted only limited control over the providers that charged households informal copayments. When focusing on the relationship between households and providers, high out-of-pocket payments indicate a strong regulatory role of the market over the system of provider remuneration. Healthcare professionals determined fees for informal services with a profit-orientation that violated the scheme's underlying principle of free access and universal coverage, resulting in a commodification of services. At the same time, it increased the level of intra-collective regulation of the relationship between households as financing agents and patients. The main policy instruments used by the state were ownership and legislation.

In the government scheme for the poor, the MoH was the key financing agent and the owner of service providers. In particular, the scheme financed curative care, rehabilitative care, and long-term care provided in inpatient settings at MoH facilities and university hospitals. Patients had no access to facilities run by the SSK or private hospitals. Accordingly, as part of Article 9 of the Law Concerning State Coverage of Treatment Expenses of Citizens Who Lack the Ability to Pay by Issuing a Green Card from 1992, provider access to the scheme was regulated exclusively by the MoH.

In terms of provider compensation, state hospitals were formally financed by two sources: transfers from the central budget and revolving funds. In general, remuneration of services and the specific system of provider compensation was strictly regulated by the MoH. According to the Civil Servants Law from 1965, health professionals working in hospitals were civil servants and conditions of their remuneration were decided upon by the central state. Likewise, the state determined the financial capacity of hospitals in the form of line-item budgets, and hospital management had no authority to shift resources between budget lines (World Bank 2003b, 134). Accordingly, the main policy instruments of the scheme were ownership and legislation.

However, state-owned hospitals had the right to establish revolving funds, which were fueled by copayments charged to social insurance agencies as well as patients. The budgets of revolving funds established by MoH hospitals needed the approval of the ministry's General Directorate of Curative Services. Revolving funds established by university hospitals needed the approval of the president of

the respective university. The level of copayments was based on a pricing list which was jointly compiled by the MoH and the MoF.

The state appeared to exert a high level of control over the relationship between providers and households, as well as the social insurance agencies, which were complementary financing institutions of the scheme (Ibid., 135-36). However, revolving funds were not subject to the restrictive regulations that determined the usage of public funds. In fact, they followed procurement procedures of for-profit actors and a significant amount of the funds were used to increase staff salaries at the given facility.¹¹⁸ Accordingly, the level of state regulation of provider remuneration was limited when focusing on the relationship between providers and social insurance agencies. The level of state regulation over provider remuneration was even lower in the relationship between households and providers. As discussed in Chapter 5, informal out-of-pocket payments in Turkish hospitals greatly hindered access to and decreased equality within the government scheme for the poor but also in the hospital sector in general. In particular, so-called knife payments (*bıçak parası*), informal payments charged by physicians for surgical operations, put a significant financial burden on households (Tatar et al. 2007, 1038).

Furthermore, prior to the HTP, state-employed doctors had the right to work part-time in private practices and hospitals, and were even entitled to see patients at public facilities after 4pm for private consultation. Prior to the HTP, 57 percent of physicians worked in both public and private settings. The opportunity to work in private settings allowed doctors in Turkey to increase their chronically low public sector wages. However, it aroused significant moral and ethical problems in the Turkish healthcare system and made outpatient care especially vulnerable to corruption. This put a significant additional burden on the family and discouraged patients from seeking professional medical assistance when sick. These policies and low levels of state regulation of the relationship between households and providers in general, further contributed to the dependence of patients on their families and the high level of intra-collective regulation within the scheme.

¹¹⁸ The relative autonomy of providers in managing revolving funds appears remarkable as MoH hospitals were traditionally governed by a top-down command and control style. The MoH staffed the managing board of all of its hospitals, consisting of a chief physician, a head nurse and a hospital director. The level of financial and administrative autonomy of public hospitals is very limited. All medical personnel were recruited and assigned centrally by the MoH. In comparison to MoH facilities, university hospitals had a higher level of autonomy as chief physicians and management were chosen by the university. However, as university doctors are also members of a medical faculty they were appointed centrally by the Council of Higher of Education (*Yükseköğretim Kurulu*). Physicians at university hospitals today retain their civil servant status and are reimbursed through salaries. The budgets of university hospitals are approved by the council and hence resemble the procedures at other public hospitals (World Bank 2003 b, 74-78).

In sum, the state was the key regulator of the relationship between providers and financing agents in the government scheme for the poor. It controlled provider access to the scheme and the system of provider remuneration. The main policy instruments were ownership and legislation.

However, my research has also uncovered significant variations in the level of state-control. The MoH strictly controlled the remuneration of providers when funds came from its own budget. However, a number of policies, as well as generally low levels of state regulation, allowed providers to increase their low salaries. The state established the legal framework that allowed hospitals to set up revolving funds and use formal copayments from social insurance agencies and households to remunerate providers at their own will. Furthermore, the state created the legal conditions that allowed physicians to formalize household out-of-pocket payments. In consequence, the relationship between households and providers was predominantly market-driven. This led to a commodification of services and increased the dependence of patients on their families as well as the level of intra-collective regulation in the scheme.

The MoF was the key financing agent in the government employee scheme for active civil servants, while in the government employee scheme for retired civil servants it was the *Emekli Sandığı*. Both schemes financed curative care, rehabilitative care, long-term care services, as well as medical goods provided by MoH and university hospitals on a fee-for-service basis. Providers financed by the scheme were mostly state-owned. Accordingly, the state owned and financed most services. Provider access to the scheme was regulated by the MoH and individual universities, which oversaw licensing, staffing, and management of individual facilities (World Bank 2003b, vi). Under certain conditions, the schemes also financed services provided by private non-profit and for-profit facilities. Remuneration of these services and the specific system of provider compensation was individually bargained between the MoF and the respective provider (Savaş et al. 2002, 34).

Accordingly, the state was the predominant regulator of the relationship between financing agents and providers for the government employee schemes. It determined provider access to the scheme and the system of provider remuneration. The main policy instruments were ownership and legislation as well as the appointment of members to key positions in the decision-making boards of the *Emekli Sandığı*. In some cases, individual agreements between the MoF and private providers were made.

However, households of patients that were covered by these schemes also had to make high formal and informal out-of-pocket payments for medical services (Tatar et al. 2007, 1035). Accordingly, state policies such as the establishment of revolving funds and the formalization of out-of-pocket payments also affected the relationship between households and providers. However, given the higher socio-economic status of civil servants, the outcomes of these policies were less dramatic. When compared to those who were covered by the Green Card, *Emekli Sandığı* insureds were significantly more likely to seek care when sick (World Bank 2003b, 37).

The social insurance schemes administered by the SSK and the *Bağ-Kur* financed curative, rehabilitative, and long-term care provided by state-owned outpatient and inpatient care facilities. Accordingly, the access of providers to the schemes was regulated by the MoH. Additionally, as discussed in chapter 6.1, the SSK ran its own network of outpatient care facilities and hospitals until 2005, which provided inpatient and outpatient services. However, the MoH regulated the access of these facilities to the scheme by determining physical standards, staffing, and equipment of state-owned facilities. SSK hospitals were centrally steered by the SSK's General Directorate for Health Services. The managerial boards, as well as the medical staff of SSK hospitals, were chosen centrally by the Directorate (World Bank 2003b, 74-75).

As discussed in Chapter 5.2, the SSK and the *Bağ-Kur* were charged fees-for-services which were determined by the MoF and directly charged by the MoH and university hospitals. Fees-for-services provided in SSK hospitals were determined centrally by the SSK's General Directorate for Health Services. However, prices only applied to non-SSK members. The services provided for SSK members were financed through annual budgets transferred by the SSK to the respective facility and staff had civil servant status. Accordingly, remuneration of service providers was regulated by the central state. All expenditures of SSK hospitals needed to be approved by the SSK and funds were only transferred for specific payments (Ibid., 72).

In sum, the state regulated the relationship between financing agents and providers in the social insurance schemes. The main policy instruments were ownership and regulation. Furthermore, the state exerted a high level of institutional control over the decision-making bodies of the SSK and the *Bağ-Kur*. Access to the schemes and systems of provider remuneration were determined by legislation. In the case of SSK-owned hospitals, the MoH set the standards that regulated access to the scheme. High informal and formal insurant out-of-pocket payments for medical services indicate that state policies, such as the establishment of revolving funds and the formalization of informal copayments, contributed to the commodification of services and increased the dependence of patients on their families.

With regard to the state's role in the regulation of the relationship of financing agents and providers in voluntary health insurance schemes, a mixed picture emerges. When providers were market-owned, access to the schemes was loosely regulated by the MoH. Private hospitals, as well as polyclinics and private practices in Turkey, fell under the jurisdiction of the MoH under the Private Hospitals Law (*Hususi Hastaneler Kanunu*) of 1933 and the Private Hospitals Charter (*Özel Hastaneler Tüzüğü*) of 1983. The ministry controlled their access to the healthcare market by setting and implementing the legal framework regarding physical standards, staffing, and equipment. Once private providers were licensed by the MoH, they were free to contract with individual insurance companies. Prior to the HTP, private hospitals had, in theory, only limited autonomy to set fees-for-services. The chargeable costs

for care services, medical routine visits, as well as fees for beds and rooms, were determined by a pricing commission.¹¹⁹ However, in practice, most private hospitals freely determined treatment fees. Furthermore, as long as they fulfilled the minimum standards, they remained unregulated with regard to staff recruitment and remuneration. Finally, state control over private hospitals did not include a comprehensive assessment and regulation of medical treatment, a further consequence of a lack in formal standards (World Bank 2003b, 86). Accordingly, the state did little to regulate the relationship between for-profit private health insurance funds and non-profit and for-profit private providers of healthcare. The remuneration of service providers and systems of provider compensation was mostly market-driven. In contrast, the state strictly regulated the relationship between private insurance companies and state-owned providers. The remuneration of services and the specific system of provider compensation in MoH and university hospitals was determined by the MoF and the MoH which determined fees-for-services.

According to the SHA 2011's categorization, households can function as service providers as well as financing agents. Prior to the HTP, household schemes financed all functions of healthcare of individuals who were not covered by the government and social insurance schemes. They also financed services provided by for-profit healthcare providers, as well as medical services, which were not part of the benefits catalogs of the respective schemes, such as dental care or laboratory services. State institutions, in theory, regulated the relationship between state-owned providers and households, as formal fees-for-services were determined by the MoH and the MoF. However, as discussed above, the relationship between households and state-owned service providers was, to a significant degree, market-driven. The remuneration of service providers owned by the market and non-governmental actors by households was exclusively market-driven. Furthermore, households functioned as complementary financing agents or financing institutions in all government and social insurance schemes. The state determined through legislation the levels of copayments for medical goods, which varied significantly across the schemes.

As discussed, households also played a key role as providers in the Turkish healthcare system. Prior to the HTP, the state did little to strengthen the family's capacity to fulfill this role. Financial incentives such as allowances or tax-cuts for families that provided home care did not exist. Accordingly, the relationship between households as financing agents and households as providers was regulated entirely intra-collectively. Given that prior to the HTP, households were often both the main financing agent and provider in the realm of long-term care, the burden on families has to be considered considerable (Zencir et al. 2005).

¹¹⁹ The commission comprised representatives from the MoH's provincial health directorate, the Turkish Medical Association TTB, the local chamber of commerce, the municipality, and a chief physician from a local state hospital or health center (World Bank 2003b, 86).

In sum, I have revealed strong variations in terms of the regulation of the relationship between service providers and financing agents. My findings show that across the different schemes, the level and style of state control over providers has varied significantly. Ownership criteria and the type of revenue were decisive for the level of state engagement. State Institutions strictly regulated the relationship between state-owned healthcare providers and state or societal-owned financing agents in a hierarchical manner, either through ownership, legislation, or institutional control. In contrast, the relationship between market and societal-owned providers and for-profit financing agents of voluntary health insurance schemes were predominantly market-driven. I have thus shown that public policies aimed at increasing the revenues of state-owned providers led to a commodification of services and increased patients' dependence on their families. In this context, I have discussed how policies that regulated the establishment of revolving funds in state-owned hospitals and the right of state-employed physicians to work part-time in the private sector had a strong impact on the relationship between households and providers. At the same time, generally low levels of state regulation of the relationship between households and for-profit providers increased the level of commodification of healthcare services and the dependence of patients on their family's capacity and willingness to pay for services. In the following, I examine how this picture has changed with the implementation of the AKP's healthcare reforms.

7.2.2 Regulation of the relationship between financing agents and service providers since the HTP

An analysis of the financing dimension of the Turkish healthcare system has shown that the reforms of the HTP did not change the role of the state as the key financing agent of the government preventive and outpatient curative care scheme. However, the reforms had a significant impact on provider access to the scheme. Prior to the HTP, doctors at MoH curative outpatient care facilities were government employees working in state-owned facilities financed and managed by the MoH. Since the implementation of the reform, facilities are staffed by self-employed family physicians who gain access to the scheme by signing contracts with the provincial branches of the MoH, the Provincial Health Directorates. Thus, a purchaser and provider split was established. The MoH is the key financing agent of the current scheme, which purchases services from self-employed providers working for-profit.

According to Article 3 of the Family Medicine Law, family physicians treat patients assigned to them and are paid by the MoH on a per capita basis. They are also responsible for managing their health facilities. In consequence, doctors working in the scheme have lost their civil servant status.

While the state no longer functions as the provider of care, it continues to strictly control the remuneration of service providers and determines the system of provider compensation. In addition to traditional instruments, the state regulates provider remuneration through contracts, financial

incentives, standards, as well as penalties. Doctors are employed on performance-based contracts and full salaries are only paid if performance targets for maternal and child health, including standard vaccinations and antenatal visits, are met. At the same time, family physicians are given financial incentives of up to 40 percent of their base salary if they choose to work in underserved regions. While Article 4 of the Family Medicine Law grants family physicians the right to rent their own facilities, most continue to rent facilities owned by the MoH. Many of the health posts and health centers that were established prior to the HTP reforms were transformed into family practice facilities (World Bank 2013).

These findings suggest significant changes in the policy instruments that the state uses to achieve the scheme's main policy goal of universal healthcare. Critics argue that the introduction of financial incentives for physicians financed through the schemes could result in lower quality of services as doctors have less time to focus on the individual needs of patients (Eskiocak 2007; Öcek et al. 2014). While improvements in health outcomes, as discussed in Chapter 5, suggest the opposite, more research is necessary to evaluate the impact of the reforms on the quality of preventive and outpatient curative care.

Furthermore, we know little about the impact of the reforms on informal out-of-pocket payments charged by providers. As informal out-of-pocket payments still constitute an obstacle to universal access, the relationship between financing agents and providers in the scheme continues to be at least partly market-driven. However, higher utilization rates and improved health outcomes suggest a significant decommodification of services financed by the scheme. I conclude, therefore, that since the reforms, the state has strictly regulated provider access to the scheme, as well as provider remuneration, through a mixture of old and new policy instruments, which includes legislation but also financial incentives, individual agreements and standards. While many facilities continue to be owned by the state and rented out to family physicians, the establishment of a purchaser and provider split suggests a transformation of the state's role from ownership and provision toward regulation.

In the government and social insurance schemes managed by the SGK a mixed picture emerges with regard to the regulation of the relationship between providers and financing agents. The initial roadmap of the HTP drafted by the MoH comprised a series of reforms, which aimed at a fundamental restructuring of inpatient care in Turkey. In particular, a full separation of healthcare financing, planning, and provision was to be implemented. The MoH was to be stripped of its active role in healthcare financing and provision and transformed into a regulating body responsible for healthcare management and quality control. The SGK was to be established as the main purchaser of healthcare services. The provision of public inpatient care was to be initially centralized in the hands of the MoH and, in a second step, decentralized and provided by hospitals, which would contract services individually from the SGK (MoH 2003, 32).

A decade after the launch of the HTP, this roadmap has only been partially implemented. The transfer of all schemes to the SGK, at least in theory, implied a purchaser and provider split. I have shown that the SGK has become the key financing agent, which centrally pools the resources of the various schemes. However, the MoH still effectively functions as a financing institution of the schemes, covering the permanent costs of its facilities, including maintenance costs and salaries. Furthermore, the MoF remains a key financing institution of the schemes as it compensates the massive deficits made by the SGK from the central budget.

With the transfer of SSK hospitals to the MoH, non-governmental actors have lost importance, and as the owner of MoH and university hospitals, the state has become the key provider of healthcare services. Accordingly, the hospital sector continues to be regulated by the state. Access to the schemes by state-owned providers is controlled by the MoH, which is responsible for certificating healthcare institutions and personnel.

According to Article 72 of the Social Security and General Health Insurance Law, fees-for-services are determined by a Healthcare Service Pricing Commission. Seven of the committee's nine members are appointed by government institutions. Only two members are appointed by the SGK. Accordingly, I conclude that after the implementation of the HTP, the remuneration of state-owned providers continues to be regulated by the state.

However, MoH and university hospitals still manage revolving funds which are fueled by copayments collected from the SGK. In addition, health professionals working in state-owned facilities have retained their civil servant status and receive a salary, which is set by the central state as part of the Civil Servants Law. However, the HTP brought significant changes regarding additional income of physicians. In 2010, the Law Regarding Full-Time Employment of University and Health Personnel (*Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına Dair Kanun*) was passed, which prohibits physicians working in state-owned hospitals from earning additional income in private facilities. The reform was met with great criticism from health professionals and after a decision by the Constitutional Court, university professors were exempted from the regulation. However, the law marks a significant shift in public policy and indicates a stronger level of regulation of the state over healthcare providers.

A policy shift can also be seen in the stricter regulation of the relationship between the SGK and societal, as well as market-owned providers. Since 2009, a SGK commission ranks private hospitals according to five different categories. Based on this ranking, hospitals that have signed a contract with the SGK can charge insurants between 30 to 70 percent of the fee determined in the Health Implementation Guide to the patient (SGK 2011). Given that fees-for-services, in practice, used to be regulated by the market, the new policy marks a significant increase in state control.

However, Article 73 of the Social Security and General Health Insurance Law allows providers to charge patients for hotel services, which may be up to three times higher than the fees for medical services. This loophole enables hospitals contracted with the SGK to circumvent pricing regulations for medical services. In practice, this allows providers to use copayments for hotel services to finance medical services and facility running costs. The policy, therefore, integrates households into the scheme as financing institutions. The financial burden of the reform is shifted from the providers to individual families.

In this context, it is all the more understandable that patients spend on average half as many nights in private hospital inpatient care as they do in public hospitals, as illustrated in the findings in Chapter 5. Many factors may contribute to the short stays in private hospital settings in Turkey but it can be assumed that costs play a significant role.

In voluntary health insurance schemes, the AKP reforms have not brought about significant changes to the regulation of the relationship between providers owned by the market or non-governmental actors and financing agents. Private institutions that have not signed a contract with the SGK are free to set their own prices for services provided. However, according to Article 73 of the Social Security and General Health Insurance Law, they are obliged to provide emergency care free of charge. Likewise, the relationship between private providers and health insurance companies continues to be regulated by the market. The state's engagement is limited to setting the legal framework that allows the remuneration of providers by voluntary insurance schemes based on market mechanisms.

Accordingly, while household schemes have lost momentum, modes of regulation of the relationship between households and providers have not changed. According to the Private Hospitals Law of 1933 and the Private Hospitals Charter of 1983, provider access to the healthcare market continues to be regulated by the MoH. Fees-for-services in state-owned facilities are determined by state institutions. The system of remuneration of providers that are owned by the market and non-governmental actors continues to be corporate and market-driven. According to Article 12 of the Insurance Law of 2007, the state does not impose a limit on fees-for-services provided to patients who are not insured with the SGK.

Households continue to play a key role as providers in the Turkish healthcare system. Since 2006, families who take care of their elderly, sick, or disabled members at home receive financial incentives in the form of an allowance determined by the MoF, as long as they meet certain conditions. The entitlement to benefits depends on the degree of disability or sickness of the patient, the necessity of care and the financial status of the household. In particular, Article 2 of the Regulation Concerning the Identification of Disabled in Need of Care and Determining the Guidelines for Care Services (*Bakıma Muhtaç Özürlülerin Tesbiti ve Bakım Hizmeti Esaslarının Belirlenmesine İlişkin Yönetmelik*) from 2006 determines that only households with a per-head income of less than two-thirds of the minimum wage

are entitled to an allowance. Caregivers must be relatives of the patients or healthcare professionals with a certification from the Ministry of Education. However, the definition of a relative in Article 4 is very broad as fourth degree relatives are mentioned in the decree defining entitlement criteria. This policy is significant when we consider that in the financing dimension most recent policies refer to the nuclear family as an economic and social unit. However, complementary to the reform of home care provision it illustrates that the policy goal of strengthening the capacity of the family to finance and provide care to its members has gained momentum.

In sum, the HTP reforms have led to significant shifts in the regulation of the relationship between financing agents and providers and to a strengthening of the state's role. In the government preventive and outpatient curative care scheme, the state remains the key regulator. However, we can observe changes with regard to the policy instruments and a shift toward a more regulatory role of the state.

In the government and social insurance schemes administered by the SGK, this new role of the state becomes even more tangible. Policies that allowed providers in state-owned facilities to resort to household revenues have been repealed. In contemporary Turkey, provider access to the schemes and their remuneration is regulated exclusively by the state. However, the policy instruments used to regulate this relationship have not changed. Accordingly, ownership and legislation remain the predominant tools for state intervention.

The state has further increased its control over the system of remuneration of providers that are owned by the market and non-governmental actors. In this context, besides legislation, instruments such as individual agreements with hospitals have gained momentum. These findings show that in order to protect citizens from social risks related to sickness, the state increasingly regulates the role of the family, the market, and non-governmental actors in the financing and provision of healthcare.

As already discussed, these changes have to be seen in the context of the significant increase in market-owned providers of inpatient curative care. My findings suggest that the state increasingly regulates the role of market actors and in particular the system of provider compensation. These developments point to a transformation of the role of the state in the Turkish healthcare system from provider to regulator of services (Majone 1997). However, as discussed, loopholes exist and given the marginal role of voluntary health insurance schemes, the emergence of for-profit hospitals is predominantly financed by households. These findings further validate the claim made by Yılmaz that the AKP reforms have shifted the causes of inequalities in access to healthcare away from occupational status toward income level (Yılmaz 2013).

In voluntary health insurance schemes, I have not found any significant changes with regard to the regulation of the relationship between financing agents and providers. The state's role is limited to

setting the legal framework that allows market actors to determine access to the schemes and the remuneration of providers.¹²⁰

In household schemes, modes of regulation of the relationship between households and providers have not changed. The system of remuneration in state-owned facilities is determined by state institutions. The system of remuneration of providers owned by the market and non-governmental actors continues to be corporate and market-driven. However, the AKP reforms mark a significant change in the relationship between the state and households as service providers. Complementary to reforms in the provision dimension, this policy shift illustrates a growing importance of the policy goal of strengthening the capacity of the family to finance and provide care to its members.

7.3 Regulation of the relationship between providers and patients

The analysis I provide in this section focuses on the changing role of the state, the market, non-governmental actors and the family in the regulation of the relationship between service providers and patients. I examine (i) who regulates patient access to service providers and (ii) who regulates the benefits packages of the schemes that existed prior to and after the AKP reforms (Wendt et al. 2009, 80). Furthermore, (iii) I examine whether the policy instruments used by the state have changed.

7.3.1 Regulation of the relationship between service providers and patients before the HTP

Within the government preventive and outpatient care scheme, legislation determined that patients could only access service providers owned by the MoH. However, they were free to choose between these facilities without limitations. Likewise, the benefits catalog financed by the scheme was broadly defined by the Law on the Socialization of Health Services, and by subsequent ministerial decrees. Hence, the relationship between patients and providers was regulated by the state, giving patients a high level of autonomy to choose among the existing healthcare providers.

In the government scheme for the poor, patient access to service providers was limited by legislation. Patients only had access to inpatient curative and rehabilitative care services provided in state-owned facilities. They could choose freely between MoH facilities, however, to access services provided at university hospitals referral was mandatory. The benefits catalog was defined by Article 2 of the Law Concerning State Coverage of Treatment Expenses of Citizens Who Lack the Ability to Pay by Issuing a Green Card and further specified in ministerial decrees. In the government scheme for the poor the

¹²⁰ See the Private Hospitals Law of 1933 and the Private Hospitals Charter of 1983, as well as the Insurance Law of 2007.

state also regulated the relationship between service providers and patients, giving patients the autonomy to choose among facilities.

In the government employee schemes for retired and active civil servants, as well as the social insurance schemes, SSK and *Bağ-Kur*, patients had, by law, access to inpatient and outpatient curative care, as well as rehabilitative and long-term care provided in public facilities. Furthermore, the government employee schemes and the *Bağ-Kur* scheme allowed access to private providers. Insurants of the SSK scheme also had access to curative and rehabilitative inpatient and outpatient care providers owned by the SSK.

A number of studies argue that high levels of patient autonomy and the absence of a referral system had a negative impact on service quality and cost efficiency. Given the low quality and limited access to the services financed by the government outpatient curative care scheme, many patients consulted specialists working in outpatient departments of state-owned hospitals, which caused long waiting times and high healthcare costs.¹²¹

In voluntary health insurance schemes, access to service providers, as well as the range of services offered to patients, depended on the individual patient's insurance plan. The state did not regulate private health insurance holders' access to healthcare providers, however, patients did not have access to facilities owned by the SSK. Likewise, the benefits catalog of voluntary health insurance schemes were regulated exclusively by market actors.

The role individual family members play in the provision of care for sick relatives depends on the household's capacity and willingness to provide services (OECD et al. 2011, 178-79). Accordingly, the regulation of the relationship between patients and households as service providers is predominantly regulated intra-collectively. However, public policies have a distinct impact on the scope of services households provide. In the following, I highlight some examples of such policies.

As already discussed, family members have traditionally played a significant role in inpatient curative care settings, however, only a few laws have regulated the role of *refakatçi*. The Regulation on the Administration of Inpatient Care Institutions from 1973 determines that:

Based on the permission of the head physician and the necessary consultation with healthcare management, relatives of patients who underwent major surgery or suffer from serious illness as well as mothers or relatives of children who are in need of care of their mothers may accompany a patient. Men are not allowed to companion female patients. [...]

Companions will be charged half the price of respective inpatient's care category. Fees may not be charged from patients who receive care free of charge. Companions may rest on beds or chaise longue provided by the hospital and should be provided with food from the hospital. With the permission of the chief physician they may bring in certain foods from outside.

¹²¹ See: World Bank 2003b, 17; Savaş et al. 2002, 77; OECD and World Bank 2008, 113.

Companions have to care for the patients within the framework of the directives given by physicians, have to follow hospital regulations and may not receive services themselves (Articles 64 and 65).¹²²

In 1984, similar regulations were adopted for nursing homes. The Regulation on Retirement Centers (*Huzurevleri Yönetmeliği*) issued by the MoH determines that sick inhabitants have the right to be accompanied by a *refakatçi*, who are charged half of the patient's fees and are, in return, provided with a bed and food (Article 69). The decree does not differentiate between genders. Hence, men are allowed to accompany patients in nursing homes. According to Article 18 of a Ruling of the Council of Ministers from 1982, workers have the right to paid leave if they provide *refakatçi* services to their children, spouse, or parents.

As I have shown in Chapter 6.1, hospital staff, in practice, determined which medical or social services were delivered. Existing studies show that *refakatçi* were engaged in medical care of patients. Accordingly, low level of state regulation enabled providers to engage family members in care provision to save costs and overcome shortages in personnel.

Another example of the linkage between public policies and the role of the family in care provision is the regulation of the pharmaceutical market in Turkey. As discussed in Chapter 5.1, high levels of self-medication contributed significantly to medical costs, which amounted to one third of out-of-pocket payments. The case of self-medication is even more remarkable as it blurs the division between healthcare provider and recipient as the patient himself becomes the healthcare provider. At the same time, public policies, such as the classification of pharmaceuticals as non-prescription drugs, facilitates self-medication or the provision of medication by non-professionals.

Article 24 of the Law on Pharmacists and Pharmacies (*Eczacılar ve Eczaneler Hakkında Kanun*), which was passed in 1953, determined that pharmaceuticals should only be sold based on a prescription. However, the implementation of state regulations by pharmacists was only loosely monitored and controlled. In consequence, patients had unregulated access to medical goods, which led to high levels of self-medication or medication through family members. The low regulation of the pharmaceutical market allowed patients, as well as their family, to provide medical goods without oversight. At the same time, the state strictly regulated the pricing of medical goods, making them affordable to the public (Dorlach 2013). Both policies contributed to the predominant role of the family as a healthcare provider in the Turkish healthcare system.

¹²² The Turkish original is "Hastanelerde yatan hastaların bazı önemli ameliyat ve hastalıklarında hastaların yakınlarından biri, annesinin bakımına muhtaç çocukların anneleri veya yakınları, servis şefinin gerekli görmesi ve baştabibin onay ve izni ile hastaya refakat edebilirler. Kadın servisine erkek refakatçi alınmaz. Refakatçılar. İdarece verilecek gömleği giyerler. [...] Refakatte olanlardan yattığı sınıfın yarı ücreti alınır. Ücretsiz yatırılan hastalara refakat edenlerden ücret alınmaz. Refakatçiler hastane idaresince sağlanabilecek yataklarda veya şezlonglarda yatar ve yemekleri hastanece verilir. Verilen yemekler dışında yiyecek ve içecek istiyemezler. Ancak, baştabibin izni ile dışardan belirli yiyecekleri getirebilirler. Refakatçiler, hekimlerin direktifi çerçevesinde hastalarına bakmakla ve hastane düzenlerine uymakla yükümlü olup kendilerine hizmet edilemez."

In sum, prior to the HTP, the relationship between providers and patients was state-regulated in the government and social health insurance schemes. Access criteria and benefits catalogs of the government and social health insurance schemes were determined by legislation and regulation. In voluntary health insurance schemes, it was the market that determined access to providers and the content and range of services offered to patients. The relationship between patients and households as providers was mostly regulated intra-collectively. However, low regulation of the *refakatçi* system and sale of medical goods increased the importance of the family as a care provider.

7.3.2 Regulation of the relationship between service providers and patients since the HTP

Since the reform of the government preventive and outpatient curative care scheme, patient access to service providers has been controlled by the MoH. Family physicians that have signed a contract with the ministry must provide services to a specific list of citizens. However, according to Article 4 of the Family Medicine Law, patients have the right to change their physician if they are not satisfied with the service.

The benefits catalog financed by the scheme is determined by law and ministerial decrees. However, since the implementation of the HTP, the state has increased control over healthcare providers. A monitoring system was introduced to ensure that family physicians perform mandatory antenatal and postnatal examinations and child vaccinations (World Bank 2013, 13). Financial penalties are used to implement the regulation. According to Article 3 of the Family Medicine Law, family physicians lose up to 20 percent of their salaries if targets set by the MoH are not met.

In addition to stricter controls over service providers, the scheme's benefits catalog has also been extended. According to Article 4 of the Regulation on the Implementation of Family Medicine from 2013, family physicians have the responsibility to provide curative home care and, if necessary, coordinate the provision of specialized home care to patients.

In sum, the establishment of the family physician system was flanked by a strengthening of the state's role in the regulation of the relationship between providers and patients. The extension of the benefits catalog, as well as better access to services, has led to higher utilization rates. It can be assumed that this reduces the role of households as service providers.

In the government and social health insurance schemes managed by the SGK, access to service providers is regulated by the Social Security and General Health Insurance Law of 2006. According to Article 73, insurants have access to state-owned facilities, as well as private facilities that have signed contracts with the SGK.

The HTP reforms have harmonized the benefits catalogs of all the SGK schemes. The benefits catalog is defined in the Health Implementation Guide published by the SGK since 2007. According to Article 63

of the Social Security and General Health Insurance Law, the MoH's role is limited to consultation (see also Tatar et al. 2011, 49-50). However, according to Article 72 of the law, fees-for-services are determined by the Healthcare Service Pricing Commission. Seven of the committee's nine members are appointed by government institutions. Only two members are appointed by the SGK.

Over the last decade, the benefits catalog of the schemes administered by the SGK have been expanded to include curative, rehabilitative and long-term care services provided in home-based settings. In 2005, the Turkish Prime Ministry published the Regulation Concerning the Provision of Home Care Services (*Evde Bakım Hizmetleri Sunumu Hakkında Yönetmelik*). The document, for the first time, offers a comprehensive regulatory framework for public and private home care providers. In particular, it sets standards for the establishment and management of healthcare facilities that provide home care. Furthermore, it defines the medical and social conditions under which a patient should have access to public home care services.

Particularly striking is that prior to the HTP, home care was predominantly provided by physicians, whereas nurses have now gained prominence in home care provision. The 2008 Regulation Concerning the Specification of Minimum Requirements for Medicine, Nursing, Midwifery, Dentistry, Veterinary Medicine, Pharmaceuticals, and Architecture Training Programs (*Doktorluk, Hemşirelik, Ebelik, Diş Hekimliği, Veterinerlik, Eczacılık ve Mimarlık Eğitim Programlarının Asgari Eğitim Koşullarının Belirlenmesine Dair Yönetmelik*) ensured that home care nursing became part of the curriculum taught to nurses at medical schools. This suggests that services traditionally performed by family members, such as changing bandages and medication, are now increasingly provided by healthcare professionals. In 2015, the MoH published the Regulation on the Provision of Home Care Through the Ministry of Health and Institutions and Bound to the Ministry of Health (*Sağlık Bakanlığı ve Bağlı Kuruluşları Tarafından Evde Sağlık Hizmetlerinin Sunulmasına Dair Yönetmelik*). According to Article 4 of the regulation, home care coordination centers are to be established, at which patients or their relatives apply for home care services. During a pre-examination, patients are classified according to their medical conditions. In particular, three types of home care units with different specializations are to be established. Furthermore, the regulations require the establishment of commissions, which are responsible for service quality control and for managing complaints. These commissions are staffed by representatives from public and private healthcare institutions.

As shown in Chapter 6, the number and capacity of institutions providing institutional rehabilitative and long-term care has decreased over the last decade, while medical home care provision has been strengthened. Accordingly, the regulation of the relationship between providers and patients has to be seen in the context of recent healthcare reforms, which aim at strengthening the family's capacity to finance and provide care to its members.

In voluntary health insurance schemes, the state continues to play a limited role in the regulation of the relationship between patients and service providers. While the legal framework that allows private providers and financing agents to operate is set by legislation, access of providers to other providers and benefits catalogs of individual schemes are determined by market actors.

The relationship between patients and households as service providers continues to be based on intra-collective regulation. However, the extension of benefits catalogs in the government preventive and outpatient curative care scheme, and the various schemes administered by the SGK, has significantly reduced the burden on households. In particular, with the introduction of home care, the state has taken more responsibility in long-term care and rehabilitative care provision. More recently, the state has begun to restrict the provision of medical goods and in particular, antibiotics, and anti-depressives through a new Pharmaceutical Tracking System (*İlaç Takip Sistemi*). Furthermore, given the strong role of households in the financing and provision of medical goods, these policies, if implemented, would likely further limit the role of households in healthcare financing and provision. However, the legislation that regulates the role of *refakatçi* in inpatient settings has not changed.

These findings need to be put in context of the results of Chapter 6. My research suggests that while policymakers aim to strengthen the capacity of the family, they still perceive it as an integral actor in healthcare financing and provision.

7.4 Intermediate results: The transformation of healthcare regulation

In this chapter, I have analyzed the transformation of the regulation dimension of the Turkish healthcare system. Based on my preceding observation that a paradigm change in healthcare policy has occurred, I have explored whether the form of governance has also shifted.

My analysis has focused on the transformation process according to three different levels: (i) the relationship between financing agents and patients; (ii) the relationship between financing agents and providers; and (iii) the relationship between patients and providers. I have, furthermore, examined if the policy instruments used by the state to regulate these relationships have been altered.

In terms of the first level, the relationship of financing agents and patients, my findings show that prior to the AKP reforms, the regulatory role of the state was inconsistent. In the government and social health insurance schemes the state was the key regulator of modes of coverage and revenue systems. State institutions, in particular, steered the relationship between patients and state and societal financing agents in a hierarchical manner. In sharp contrast, the state left the regulation of voluntary health insurance schemes almost entirely to the market. Moreover, a number of policies existed, such as the exclusion of medical goods from the benefits catalogs in government schemes, and long waiting periods in the *Bağ-Kur* scheme, which integrated households into the respective schemes as

complementary financing agents. I argue that public policies were, at least partially, underpinned by the premise that the family is responsible for financing and providing healthcare to its members. Similarly, entitlement and dependency regulations point toward this principle and, to varying degrees, aimed at strengthening the family's capacity to fulfill its presumed role. In sum, these policies increased levels of intra-collective governance inherent in the various schemes.

I have also shown that the state intervened in the relationship between patients and state and societal-owned financing agents in a mostly hierarchical manner. Key policy instruments were ownership and legislation. In addition, my research highlights a remarkable trait of healthcare governance in Turkey. As outlined in the historical analysis, the institutions that administer the social health insurance schemes were established as part of a state-led nation-building project. In this chapter, I have demonstrated that the state has exerted an extraordinary high level of institutional control over these institutions by staffing their executive bodies primarily with government representatives. New, more inclusive forms of governance existed, such as agreements on copayments for outpatient curative care services between the MoH and the social insurance agencies. However, they played a marginal role. I conclude, therefore, that the state regulated the relationship between financing agents and patients through hierarchical steering.

The reforms of the AKP have introduced significant changes in healthcare governance. As shown in Table 21, these changes have affected to varying degrees the regulation of the relationship of financing agents and patients within the respective schemes.

Table 21
Changes in the regulation of the relationship between financing agents and patients, years 2003 and 2014

Scheme	2003		2014	
	Form of governance	Policy instrument	Form of governance	Policy instrument
Government preventive and curative outpatient care scheme	State-led, intra-collective	Ownership, legislation, agreements	State-led	Ownership, legislation
Government scheme for the poor	State-led, intra-collective	Ownership, legislation	State-led	Institutional control, legislation
Government scheme for Syrian refugees	--	--	State-led	Ownership, legislation
Compulsory social health insurance scheme	--	--	State-led	Institutional control, legislation
Government employee schemes for active and retired civil servants	State-led	Ownership, institutional control, legislation	State-led	Institutional control, legislation
Social health insurance scheme for employees	State-led	Institutional control, legislation	State-led	Institutional control, legislation
Social health insurance scheme for the self-employed	State-led	Institutional control, legislation	State-led	Institutional control, legislation
Voluntary health insurance schemes	Market-driven	Legislation	Market-driven	Legislation
Household schemes	Intra-collective	Legislation	Intra-collective	Legislation

Source: Own depiction

The most significant result from this table is that with the implementation of the HTP, the state has further extended its role in healthcare governance. Modes of coverage and systems of financing of the government scheme for preventive and curative outpatient care, as well as the various schemes administered by the SGK, are determined by the state. With the expansion of the benefits catalogs in the government schemes, most importantly the inclusion of medical goods, households have lost their role as complementary financing agents. Accordingly, I conclude that the level of intra-collective governance in these schemes has become marginal. However, while households have lost their regulatory function, my findings also show that the state increasingly regulates the role of the nuclear family in healthcare financing. This leads to a formalization and institutionalization of the role of the family in healthcare financing, most noticeably in the newly established compulsory social health insurance scheme.

Recent policy reforms regarding voluntary health insurance suggest that policymakers, in the long run, intend to strengthen their role as financing institutions in the scheme's administered by the SGK. However, at current state, the market decides upon modes of coverage and systems of financing. The state's role is accordingly limited to setting the regulatory framework necessary for establishing voluntary health insurance schemes. I argue that the style of state regulation of the relationship between financing agents and patients has not changed.

With regard to the instruments used by the state to implement its policy goals, the most remarkable transformation is the introduction of a purchaser and provider split in the government scheme for the poor and the government scheme for active civil servants. With the implementation of the related reforms, the SGK has become the financing agent in these schemes. The state therefore no longer regulates the relationship between financing agent and patient through ownership.

My findings do not, however, indicate a shift in the predominant mode of governance, as legislation remains the key policy instrument. Furthermore, despite the massive institutional restructuring of the social insurance administration, the state exerts an extraordinary high level of institutional control over the executive bodies of the SGK.

In terms of the second level, the relationship of financing agents and providers, I have also shown that the regulatory role of the state was incoherent. Ownership criteria and revenue type were decisive for the level and style of state engagement. The state dominated the relationship between healthcare providers and state or societal financing agents by determining provider access to the respective schemes, as well as the system of provider remuneration. My findings show, however, that a number of policies enabled state-owned providers to resort to formal and informal household out-of-pocket payments. Examples of these were the establishment of revolving funds in state-owned hospitals and the right of state-employed physicians to work part-time in the private sector. These policies increased the level of commodification of medical services and the family's role in healthcare financing. The level

of state control over the relationship between market-owned providers and the financing agents of voluntary health insurance schemes was predominately market-driven. Likewise, the regulation of the relationship between households and for-profit providers was regulated by the market. The state did not interfere in the pricing of medical services in market-owned facilities.

Corresponding to the first level of regulation, the state intervened in the relationship between state and societal-owned financing agents and providers through hierarchical steering. Key policy instruments were legislation and ownership in the government schemes, as well as institutional control in the social health insurance schemes.

My research shows that the AKP reforms have introduced a number of significant changes with regard to the relationship between financing agents and providers. These findings are summarized in Table 22.

Table 22

Changes in the regulation of the relationship between financing agents and providers, years 2003 and 2014

Scheme	2003		2014	
	Form of governance	Policy instrument	Form of governance	Policy instrument
Government preventive and curative outpatient care scheme	State-led, market-driven	Ownership, legislation	State-led	Legislation, financial incentives, agreements, standards
Government scheme for the poor	State-led, market-driven	Ownership, legislation	State-led	Ownership, institutional control, legislation, agreements
Government scheme for Syrian refugees	--	--	State-led	Ownership, legislation, agreements
Compulsory social health insurance scheme	--	--	State-led	Ownership, institutional control, legislation, agreements
Government employee schemes for active and retired civil servants	State-led	Ownership, institutional control, legislation	State-led	Ownership, institutional control, legislation, agreements
Social health insurance scheme for employees	State-led	Ownership, institutional control, legislation	State-led	Ownership, institutional control, legislation, agreements
Social health insurance scheme for the self-employed	State-led	Ownership, institutional control, legislation	State-led	Ownership, institutional control, legislation, agreements
Voluntary health insurance schemes	Market-driven	Legislation	Market-driven	Legislation,
Household schemes	Market-driven, corporate governed, intra-collective	Legislation	Intra-collective	Legislation financial incentives

Source: Own depiction.

This schematic presentation illustrates the consistent prominence of the state as the key regulator of the relationship between financing agents and providers. The MoH determines access of providers to the government scheme for preventive and curative outpatient care, as well as the schemes administered by the SGK. Their inherent systems of provider remuneration are likewise decided upon by the state. My findings, furthermore, show that the state has extended its control over providers and has annulled policies that enabled state-owned providers to resort to household revenues. In addition, medical goods have been included in the benefits catalogs of the government schemes. As a result, households have lost their roles as financing agents and medical services have been decommodified.

The AKP government has, furthermore, set the legal framework that allows the SGK to purchase services from market-owned providers. While providers are entitled to charge copayments from households or voluntary insurance schemes, these payments are limited by the state. Given the low level of state regulation of for-profit providers prior to the HTP, this is a remarkable step. However, the relevant legislation creates a loophole, which allows providers to shift the financial burden toward households by charging them disproportionately high hotel costs. This again illustrates that policymakers perceive the family as an integral actor in healthcare financing. At the same time, I have highlighted examples of policies that indicate a growing commitment by policymakers to strengthening the capacity of the family. One striking example the government giving financial incentives to families that provide homecare. The AKP reforms have not, however, changed the mode of regulation of the relationship between private providers and health insurance companies, which is continues to be market-driven.

When focusing on the policy instruments used by the state, I have shown the prominence of ownership, legislation, and institutional control. However, new policy instruments have also gained relevance. Especially in the government scheme for preventive and outpatient curative care, the state has aimed to enhance the performance of doctors through individual contracts, financial incentives, standards, as well as penalties. In inpatient care the state regulates the relationship between financing agents and providers through hierarchical steering. The high level of state-ownership in the hospital sector shows that the state's role as the provider of services has not changed. However, in outpatient care this role has changed from provision to regulation. In this process new policy instruments have gained momentum.

Finally, my analysis has shown that the state was the regulator of the relationship of patients and providers prior to the AKP's reforms. Patient access to providers and benefits packages of the government and social health insurance schemes, were determined exclusively by government institutions. However, patients had relative autonomy in being able to choose between providers. In voluntary health insurance schemes, the relationship between patients and providers was market-driven, however, given the low coverage, the regulatory role of market-actors was marginal.

I have furthermore examined how the state regulated the role of households as services providers and highlighted the relevance of two policies. First, the state created a legal framework for the *refakatçi* system, which allowed state-owned hospitals to integrate family members into care provision. Second, low levels of state control over the sale of pharmaceuticals in combination with policies that kept prices of medical goods low, contributed to high levels of self-medication and strengthened the family's role in service provision. The main policy instrument used by the state in this context was state legislation.

In comparison to the other levels of regulation, the HTP has only had a limited impact on the regulation of the relationship between providers and patients. The results of my analysis are shown in Table 23.

Table 23
Changes in the regulation of the relationship between providers and patients, years 2003 and 2014

Scheme	2003		2014	
	Form of governance	Policy instrument	Form of governance	Policy instrument
Government preventive and curative outpatient care scheme	State-led	Legislation	State-led	Legislation
Government scheme for the poor	State-led	Legislation	State-led, corporate-governed	Legislation
Government scheme for Syrian refugees	--	--	State-led	Legislation
Compulsory social health insurance scheme	--	--	State-led, corporate-governed	Legislation
Government employee schemes for active and retired civil servants	State-led	Legislation	State-led, corporate-governed	Legislation
Social health insurance scheme for employees	State-led	Legislation	State-led, corporate-governed	Legislation
Social health insurance scheme for the self-employed	State-led	Legislation	State-led, corporate-governed	Legislation
Voluntary health insurance schemes	Market-driven	Legislation	Market-driven	Legislation
Household schemes	Intra-collective	Legislation	Intra-collective	Legislation

Source: Own depiction.

In contemporary Turkey, patient access to providers and the benefits catalogs of the government and social health insurance schemes are state regulated. In this context, restrictions on patient autonomy in the government scheme for preventive and curative outpatient care are significant. However, a referral system has not been implemented.

Patient access to providers in the schemes administered by the SGK is likewise regulated by the state. However, the state only loosely regulates the benefits catalogs of the SGK, which are broadly defined by law. While fees-for-services are determined by a commission dominated by state representatives, the benefits catalog itself is defined by the SGK. In contrast, state control over the relationship

between providers and patients in voluntary health insurance schemes remains limited. The market decides on access to providers and the benefits package. When focusing on the regulation of the role of households as services providers, recent changes regarding the sale of pharmaceuticals stand out. The stricter regulation of the sale of antibiotics will most likely formalize the provision of medical goods and reduce the role of households as service providers.

When focusing on the policy instruments I have not discovered any changes. The state regulates the relationship between providers and patients through legislation. In the following, I discuss the validity of the hypotheses that have structured my analysis in an attempt to paint a comprehensive picture of the transformation of the Turkish healthcare system under AKP governance.

8. The Turkish healthcare system under AKP governance

In this thesis, I have shown that the Turkish healthcare system has gone through a remarkable transformation since the AKP came to power. My research comprises an analysis of the shifts in the actor constellation that constitutes the Turkish healthcare system and of the changes in healthcare policy. Based on my findings, I come to the following conclusions regarding the hypotheses that have structured my analysis.

My findings validate sub-hypothesis 1.1 that the AKP reforms have strengthened the role of the state as a regulator in Turkey's healthcare system. As discussed in Chapter 7, the expansion of benefits packages, in particular the absorption of costs for medical goods, have decreased the role of the family and level of intra-collective governance. The state is now the prime regulator of the relationship between financing agents and patients. Similarly, policy changes, such as the obligation that state-employed providers work full-time, have marginalized the role of the market as a regulator of the relationship between financing agents and providers. In the regulation of the relationship between providers and patients, however, societal regulation has gained some momentum. Since 2008, the SGK has determined its own benefits catalog. Nevertheless, fees-for-services continue to be determined by the state.

I have furthermore verified sub-hypothesis 1.2 that the AKP reforms have strengthened the role of the market in healthcare provision. A total of 279 new private hospitals have been built and the share of for-profit hospitals has increased from 19.1 percent of all hospitals in Turkey in 2002 to 36.3 percent in 2013. Over the same period, the share of hospital beds in for-profit hospitals has increased from 6.7 percent to 18.8 percent. One in three surgeries are now performed in market-owned facilities. This new expansion of the market in healthcare provision is, however, limited to the hospital sector. I have shown that for-profit providers have significantly lost momentum in outpatient care provision.

Based on my findings, I can furthermore validate sub-hypothesis 1.3, which argues that AKP policies have strengthened the role of non-governmental actors as financiers in Turkey's healthcare system. This is most evident when considering the transfer of the government scheme for the poor and the government employee scheme for active civil servants to the SGK. Furthermore, a significant share of the population that was previously excluded is now covered by the compulsory social health insurance scheme under current legislation.

With regard to sub-hypothesis 1.4 that the reforms of the AKP have decreased the role of the family in healthcare financing and provision, my findings are inconsistent. I have found clear evidence that the family has lost momentum in healthcare financing. The share of out-of-pocket payments of total expenditure on health has dropped from 32.9 percent in 2002 and 2003 to 17.7 percent in 2016. Most remarkably, the share of the population that has had access to inpatient care exclusively through

household schemes has decreased from 32.8 percent in 2002 and 2003 (OECD and World Bank 2008, 30) to less than 2 percent in 2014 (OECD Health Statistics 2016). New policies have increased the capacity of state-owned providers in offering home care services and the restriction of the sale of pharmaceuticals is likely to reduce the role of the family in the provision of medical goods.

However, the family continues to be a core actor in the healthcare mix in Turkey. *Bağ-Kur* insureds with premium debt lose entitlement to services and, hence, end up relying on household schemes. Through the *refakatçi* system, relatives continue to be integrated into inpatient care provision in state-owned hospitals. Despite the recent reforms, long-term care in particular, is still markedly underdeveloped in Turkey. The shift from institutional to home care provision furthermore reduces the choice of women in terms of their role as social and medical care providers.

In sum, I have revealed a substantial transformation in the actor constellation of the Turkish healthcare system. However, I have been unable to find sufficient empirical evidence to validate sub-hypothesis 1 that a system change occurred under AKP governance.

In healthcare financing, the reforms have consolidated the two-tier system in which the state dominates the financing of preventive and curative outpatient care, and non-governmental actors administer and finance different government employee and social health insurance schemes. The increase in the share of social insurance premiums from 44.2 percent of total expenditure in 2003 to 56.3 percent in 2014 illustrates that non-governmental actors remain in a prominent position.

Despite the new role of the market in healthcare provision, the state remains the key actor, owning two-thirds of all hospitals and more than 80 percent of all hospital beds (MoH 2014, 71). In preventive and outpatient curative care the state has further extended its role and recent reforms in home care suggest an increasing importance of state actors in long-term care provision.

The same holds true for the regulation dimension. The state continues to exert a high level of control over non-governmental actors engaged in healthcare financing. The policies of the AKP have, moreover, increased the regulatory role of the state over the market and the family. I conclude that a shift of the predominant actors did not occur in any of the three dimensions of the Turkish healthcare system.

My findings on the transformation of healthcare policy under the AKP likewise indicate significant changes under AKP governance. I have validated sub-hypothesis 2.1 that the AKP reforms led to changes in policy goals, instruments, and instrument settings. In Chapter 5, I have shown that prior to the reforms, the different healthcare financing schemes were underpinned by varying policy goals. Recent policy changes, such as the extension in the coverage of government and social health insurance schemes and improved benefits catalogs, point to a paradigm shift. I have demonstrated that the reforms in healthcare financing have been underpinned by the primary policy of establishing universal healthcare. According to my findings, this shift was complemented by reforms in the

provision dimension. The capacity of providers and the quality of services have increased significantly, which has led to improved access to services and increased utilization of these services across the country.

A different picture emerges when changes in policy instruments are analyzed. I have shown that the state resorts mostly to ownership and legislation when regulating the market, non-governmental actors, and the family. Furthermore, the government exerts a high level of institutional control over the non-governmental SGK by appointing state officials to its executive boards.

My findings have also validated sub-hypothesis 2.2, which argues that a mature welfare state that protects its citizens from risks on the basis of social rights has emerged under AKP governance. General Health Insurance has established a framework which, in theory, integrates all legal residents into the schemes administered by the SGK. Recent data on the coverage of SGK schemes suggests that the policies have been implemented successfully and that the healthcare system has reached near-universal coverage. Additionally, the government preventive and curative outpatient care scheme provides services to the entire population regardless of social security status. Higher utilization rates and lower out-of-pocket payments indicate that the expansion of the benefits catalogs and the modernization of state-owned healthcare facilities allow all citizens to access care. While my findings show that the healthcare reforms have led to a maturing Turkish welfare state, these results need to be put into perspective. As discussed in Chapter 5.1, Turkey still spends significantly less on healthcare than the mature European welfare states. Furthermore, the Turkish state still falls short of its social responsibility to its citizens in terms of long-term care. While recent reforms suggest a new role of the state in home care, the many patients rely on social and medical services provided by the family.

My findings furthermore show that the state progressively regulates the roles of the market, non-governmental actors, and the family in healthcare financing and provision. Accordingly, I argue that sub-hypothesis 2.3 is valid. Increasing state control over providers has led to a significant decommodification of services, while households have become increasingly formalized and institutionalized as financing agents in the compulsory social health insurance scheme. More recent changes include financial incentives to family members that provide homecare. These examples point to a new regulatory role of the state.

Finally, sub-hypothesis 2.4 argues that the state regulates the role of the market, non-governmental actors, and the family through hierarchical steering and that changes in regard to the mode of governance policy under the AKP government are path-dependent. I have demonstrated that the Turkish state interferes in society and the economy mainly through old policy instruments. I have observed, to a certain extent, a transformation of the state's role from service provision to regulation. A prime example is the introduction of the family physician system in which a purchaser and provider split has been established and the state's role has shifted from ownership to financing and regulation

of self-employed physicians. Similarly, the role of the key financing agent of the government scheme for the poor and the government employee scheme for active civil servants has been transferred from the MoH to the SGK. However, the state still provides the majority of healthcare services, and ownership remains a key policy instrument. Likewise, regulation is among the key instruments of policymakers and the state continues to exert a high level of institutional control over the SGK.

I have discovered that new policy instruments have also gained some momentum. In particular, the regulation of family physicians through financial incentives, agreements, and standards stands out. Financial incentives to families that provide home care are also noteworthy. However, policymaking and implementation in Turkey continues to be marked by a high level of hierarchical state control. With regard to the mode of governance, my findings reveal a high level of path-dependence within the AKP reforms. In the following part, I argue that this mode of governance is paradigmatic for static state-society relations in general. Nevertheless, my findings suggest that sub-hypothesis 2 is valid overall and that a paradigm shift occurred in healthcare policy under the governance of the AKP.

I conclude that the primary hypothesis of my research, which states that the political hegemony of the AKP government constitutes a critical juncture that led to a paradigm shift in healthcare policy and a system change in the actor constellation which constitutes the healthcare system of contemporary Turkey, is partly valid. While the advent of a new policy goal has led to a paradigm shift, this transformation did not replace the predominant actors in healthcare financing, provision, and regulation. In the following, I place my findings on the transformation of the Turkish healthcare system into context with the overall transformation of Turkish politics and society, and discuss the relevance of my findings for the academic debate on the transformation of welfare states.

III. Conclusion

The political and academic environment during which this thesis was conducted has changed dramatically over the last few years. The initial phase of my research took place during a period when the debate surrounding Turkey was characterized by a sense of general optimism and anticipation. A discourse emerged in numerous academic studies around the AKP slogan “New Turkey” (*Yeni Türkiye*), that envisaged the party’s rise as the beginning of a trajectory toward a more democratic and prosperous society. This optimism, however, has faded and current events have begun to recall darker periods of Turkey’s troubled history. The academic debate has likewise shifted from progressive notions of Turkey’s potential EU membership, or Turkey as a model for the democratization of Muslim societies, toward apprehensions surrounding growing authoritarianism (Esen and Gümüüşçü 2016) and the fragility of liberal conservative cultural hegemony (Tuğal 2016).

My research on the transformation of the Turkish welfare state, however, paints a more nuanced picture. Under AKP governance a mature welfare state has emerged that protects its citizens from health-related risks on the basis of social rights. I argue that the rise of the AKP marks a critical juncture that has led to a paradigm shift in healthcare policy. Prior to the AKP reforms, a patchwork of fragmented healthcare financing schemes and the exclusion of a significant share of the population from healthcare, characterized a system devoid of any consistent policies. This picture has now changed as a direct result of the AKP’s reforms in healthcare financing and provision, which have created a new paradigm of a healthcare system based on universal coverage. While the long-term impact of these reforms remains to be seen, current developments point to the beginnings of a new institutional legacy.

The extent of the recent reforms is best reflected in the changes to the actor constellation that characterize the Turkish healthcare system; the most noticeable of which has been the increasing influence of the market in inpatient care provision. Critics have voiced concern that the reforms may simply replace occupational status as the current source of healthcare inequality with that of income status. They fear a commodification of services and the emergence of a two-tier healthcare system in which the state provides universal access to rudimentary care, while wealthier segments of society opt for market-owned, high-quality providers financed by voluntary health insurance schemes (Yılmaz 2013).

A verification of this argument necessitates further research on disparities in the quality of services and utilization levels across income groups. However, three of my findings suggest a more complex picture. First, income levels were already a major cause of healthcare inequalities prior to the AKP reforms. Access to inpatient care for a third of the population was entirely contingent on their market position. High levels of service commodification were upheld by state policies, which facilitated the

common practice among healthcare providers of charging patients copayments. While these payments had a disproportionate impact on poorer households in terms of healthcare access, all segments of society were affected. However, as the AKP policies have led to a significant reduction in these out-of-pocket payments, the argument that they have resulted in a commodification of services needs to be put into perspective. Second, my research shows that recent market momentum has been limited to the hospital sector and that outpatient care has, in fact, been decommodified. Third, as I have already discussed, the state has significantly increased its control over market actors, as witnessed in the statutory caps placed on fees-for-services in for-profit hospitals, and in the restrictions put on state-employed physicians earning ancillary incomes in the private sector. This suggests that policymakers have subordinated the privatization of medical care to the new policy paradigm of establishing universal coverage.

These findings suggest that Turkey has become part of a global trend in healthcare, which Michael Moran summarizes as “more market, more state, more regulation and more bureaucracy” (1999, 90). However, my findings also indicate that the Turkish path of modernization differs from those in the mature welfare states of western and northern Europe.

The AKP reforms have not challenged the predominant perception of statehood that has underpinned the Turkish healthcare system since the late Ottoman Empire. Healthcare governance has been dominated by the state, which intervenes in society and the economy in a hierarchical manner. This becomes most apparent when considering the institutional structure of the SGK. As with previous decades, the state still controls the non-governmental SGK by appointing a significant share of the members of its executive organs. This institutional characteristic sets Turkey apart from the healthcare systems of corporatist welfare states in which the state’s role is limited to setting the legal framework that allows highly autonomous interest groups and social insurance agencies to negotiate modes of coverage and systems of finance. In contrast, these decisions have been made by the state in Turkey since the inception of the social insurance system. Accordingly, the AKP reforms have been path-dependent with regard to the mode of governance.

My research highlights a second specific trait of the Turkish healthcare system: The importance of the family. I have shown that prior to AKP rule, a number of policies existed that were underpinned by the principle that the family is ultimately responsible for the healthcare of its members, both in terms of financing and provision. However, the state did little to support this presumed role. In contrast, the AKP has lessened some of the burden on families through a series of measures: stricter regulation of providers; improved access to better services; a significant reduction in out-of-pocket payments by covering medical goods through the SGK; and establishing a network of state-owned home care providers.

At the same time, my research has revealed that state policies under the AKP aim at a formalization and institutionalization of the family's role. In healthcare financing, the establishment of the comprehensive social health insurance scheme has shifted the risk pooling for many unemployed women from the social health insurance schemes to the household. Furthermore, cohabitation is a key entitlement criterion in the government scheme for the poor and the state also imposes for-profit hospital sector reform costs on the family by allowing providers to charge high copayments for hotel costs. Accordingly, I have shown how there has been a shift from inpatient to home-based long-term care in healthcare provision. Moreover, the state gives financial incentives to families who provide home care, and the *refakatçi* system, which allows state-owned hospitals to integrate family members into medical care provision, remains in place.

Accordingly, AKP reforms continue to be underpinned by the premise that the family is responsible for the healthcare of its members. While new policies aim at strengthening the family's capacity, they are based on a highly gendered nature of healthcare provision. Universal coverage and improvements in the quality and quantity of providers have effectively decommodified healthcare by making an individual's access to healthcare less dependent on his or her market position (Bambra 2005a, 33). However, as Jane Lewis and other feminist scholars have demonstrated in the Western and Northern European welfare states, the prerequisite for this decommodification is unpaid care work carried out by women in the home. The policies of the AKP, therefore, reproduce gender roles and lower the autonomy of women.

The outcome of these reforms surrounding the family is foreseeable. The labor force participation rate of women in Turkey is already the lowest in the OECD (OECD 2016). Furthermore, Turkey's population is aging, meaning the number of patients in need of long-term care is only likely to increase in the future. AKP policies, particularly those concerning home care, have led to a familialization of healthcare and have further reduced the choice of women as to whether or not to integrate care provision into their lives. At the same time, while Turkey is set to continue its familial path of care arrangements, it can be expected that, similar to the rest of Europe, new models of care provision will gain importance. In contrast to previous times, the state will most likely interfere in these models based on the principle of subsidiarity.

The path of healthcare modernization in Turkey points to a number of contradictions, which may trigger further policy changes in the future. For example, when considering the drive to professionalize healthcare on the one hand, and the move to integrate family members into formal care provision on the other, a potential conflict area emerges. As discussed in Chapter 7, the government has recently begun to apply new policy instruments to increase the efficiency of state-contracted outpatient care providers. In inpatient care, a similar transformation may cause a conflict with the *refakatçi* system. First pilot projects have been launched in order to transfer hospital payments to DRGs. This poses the

question of how informal care provision through relatives, which currently constitutes an integral element of inpatient care provision, will be integrated into the highly standardized hospital cases of DRGs.

Another potential conflict area that could lead to policy change stems from the AKP's liberal conservative politics. A number of studies have found that in the Turkish case, a strong government does not necessarily clash with business interests (Buğra and Savaşkan 2014; Tuğal 2009; 2016). However, I argue that in the realm of healthcare, a more conflictual relationship between the state and the market may emerge.

Many factors contribute to the AKP government's public support, but two in particular stand out: economic growth based on market-friendly policies and the social and cultural inclusion of large groups in society. My findings suggest that the state aims to further integrate for-profit hospitals and health insurance companies into the healthcare financing schemes administered by the SGK. However, contrary to other sectors of the economy, state policies have significantly limited the autonomy of market-owned healthcare providers. In this context, it is important to note that the establishment of universal healthcare is one of the most convincing explanations of why so many people vote for the AKP. Accordingly, we see a conflict of interest between market actors and the AKP's constituency, which has profited greatly from the extension of social rights. Here, Paul Pierson's observation that there is a qualitative difference between politics of welfare expansion and politics of retrenchment rings particularly true in the Turkish case. Furthermore, Pierson argues that policies of welfare retrenchment bear a high risk for governments (Pierson 1996, 179). In sum, healthcare systems often become a space for political struggles among a variety of actors vying for economic resources and it remains to be seen who will dominate this struggle in Turkey (compare Moran 1999, 1).

My research shows that despite the comprehensive transformation of the Turkish healthcare system under AKP governance, two key preexisting characteristics prevail: First, a prominent mode of governance marked by a state that interferes in society in a hierarchic manner, and second, the importance of the family in healthcare financing and provision. I have shown that the AKP reforms have further institutionalized these two traits. If the recent reforms mark the beginning of a path-dependent process, as I assert, these traits will constitute lasting elements of Turkey's modernity.

These observations recall the main argument of the regime approach and pose two key questions. First, is it possible to empirically identify a predominant ethic principle, which not only underpins the complex actor arrangements that constitute the Turkish healthcare system, but also social and political relations in general? Second, is it possible to identify through cross-national comparison different types of healthcare regimes, which can be classified based on the configurations of their healthcare programs, as well as the ethic principles underpinning the institutions which finance, provide, and regulate healthcare (Wendt 2009, 77)?

With regard to the first question, both the predominant perception of state-society relations as a hierarchical process and the principle that the family constitutes the core social and economic pillar society rests upon; extend far beyond the realm of healthcare. They are principles that underpin numerous social and political institutions in Turkey. Therefore, the authoritarian perception of statehood and the dominant role of the family may reflect what Jenny White calls “the constant in Turkish society”, namely the framing of the individual in society by a collectivist logic. “Belonging to a group, whether family, community or nation, continues to be essential for social survival, as well as social identity” (White 2014, 3). However, further research is necessary to reveal how social and political institutions increase the dependence of the individual on collectives in Turkey.

The second question likewise highlights the necessity for further research. To date, only few studies include Turkey in any comparative analyses on the features that unite and divide healthcare systems. As the analytical framework of my thesis has the capacity to also highlight cross-national changes, I am confident that my theoretical and empirical findings will give impetus to future comparative research that includes Turkey. The transformation of the Turkish healthcare system does not solely promise new insights into the workings and modernization of healthcare systems in a developmental context. The comparison of Turkey’s distinct path of modernization with the transformation processes in healthcare systems of mature welfare states may also shed further light on the mechanisms through which the state, the market, and non-governmental actors engage the family in healthcare financing and provision.

Bibliography

- Abel-Smith, Brian. "The Major Pattern of Financing and Organisation of Medical Services that have Emerged in Other Countries." *Medical Care* 3, no. 1 (1965): 33-40.
- Abel-Smith, Brian, and Elias Mossialos. "Cost Containment and Health Care Reform: A Study of the European Union." *Health Policy* 28, no. 2 (1994): 89-132.
- Ağartan, Tuba. "Turkish Health System in Transtition: Historical Background and Reform Experience." PhD Dissertation. Binghamton University, 2008.
- Akyol, Mustafa. "As Davutoğlu exits, Erdoğanists demand 'obedience to the leader'." *Al-Monitor*, May 11, 2016. Accessed August 14, 2016. <http://www.al-monitor.com/pulse/originals/2016/05/turkey-erdoganists-demand-full-obedience-to-president.html>.
- Al, Behçet, Suat Zengin, Şahin Kartal, Mehmet Murat Oktay, Aycan Akçalı, and Cuma Yıldırım. "Acil önünde ve hastane çevresinde konaklayan hasta yakınları." *Türkiye Aile Hekimliği Dergisi* 17, no. 1 (2013): 18-22.
- Alber, Jens. "A Framework for the Comparative Study of Social Services." *Journal of European Social Policy* 5, no. 2 (1995): 131-149.
- Alper, C. Emre, and Ziya Öniş. "The Turkish Banking System, Financial Crises and the IMF in the Age of Capital Account Liberalization: a political economy perspective." *New Perspectives on Turkey* 30 (2004): 25-54.
- Altıntaş, Ayten. "143 yıllık tıp derneği: Cemiyet-i Tıbbiye-i Osmaniye." *SD Dergi* 14 (2010). Accessed August 14, 2016. <http://www.sdplatform.com/Dergi/388/143-yillik-tip-dernegi-Cemiyet-i-Tibbiye-i-Osmaniye.aspx>.
- Altvater, Elmar, and Birgit Mahnkopf. "The World Market Unbound." *Review of International Political Economy* 4, no. 3 (1997): 448-471.
- Anadolu Ajansı. "Rehabilitasyon klinik oteller kuruluyor." June 23, 2015. Accessed August 14, 2016. <http://aa.com.tr/tr/saglik/rehabilitasyon-klinik-oteller-kuruluyor/33586>.
- Anderson, Gerard F., and Jean-Pierre Poullier. "Health Spending, Access, and Outcomes: Trends in Industrialized Countries." *Health Affairs* 18, no. 3 (1999): 178-192.
- Anttonen, Anneli, and Jorma Sipilä. "European Social Care Services: Is It Possible to Identify Models?." *Journal of European Social Policy* 6, no. 2 (1996): 87-100.
- Aran, Meltem A., and Jesko Hentschel. "Protection in Good and Bad Times? The Turkish Green Card Health Program." Policy Research Working Paper 6178, World Bank, 2012. Accessed August 14, 2016. <http://documents.worldbank.org/curated/en/258701468172771874/pdf/wps6178.pdf>.
- Arıcanlı, Tosun, and Dani Rodrik, eds. *The Political Economy of Turkey: Debt, Adjustment and Sustainability*. Basingstoke: Palgrave Macmillan, 1990.

- Arts, Wil, and John Gelissen. "Three Worlds of Welfare Capitalism or More? A State-of-the-Art Report." *Journal of European Social Policy* 12, no. 2 (2002): 137-158.
- Atun, Rifat, Sabahattin Aydın, Sarbani Chakraborty, Safir Sümer, Meltem Aran, Ipek Gürol, and Serpil Nazlıoğlu. "Universal Health Coverage in Turkey: Enhancement of Equity." *The Lancet* 382, no. 9886 (2013): 65-99.
- Aydın, Erdem. *Türkiye'de Sağlık Teskilatlanması Tarihi*. Ankara: Naturel Kitap Yayıncılık, 2002.
- Ayduz, Salim. "Süleymaniye Medical Madrasa (Dār al-Tib) in the History of Ottoman Medicine." Foundation for Science Technology and Civilisation, 665, May 2007. Accessed August 14, 2016. http://www.muslimheritage.com/uploads/Suleymaniye_Medical_Madrasah.pdf.
- Aykan, Bahar, and Sanem Güvenç Salgırlı. "Responsibilizing Individuals, Regulating Health: Debating Public Spots, Risk, and Neoliberal Governmentality in Contemporary Turkey." *New Perspectives on Turkey* 53 (2015): 71-92.
- Azevedo, Joao Pedro, and Aziz Atamanov. "Pathways to the Middle Class in Turkey: How Have Reducing Poverty and Boosting Shared Prosperity Helped?." Policy Research Working Paper 6834, World Bank, 2014. Accessed August 14, 2016. <http://documents.worldbank.org/curated/en/561801468310468845/pdf/WPS6834.pdf>.
- Bambra, Clare. "Worlds of Welfare and the Healthcare Discrepancy." *Social Policy and Society* 4, no. 1 (2005): 31-41. (2005a).
- Bambra, Clare. "Cash Versus Services: 'Worlds of Welfare' and the Decommodification of Cash Benefits and Healthcare Services." *Journal of Social Policy* 34, no. 2 (2005): 195-213. (2005b).
- Bambra, Clare. "Defamilisation and Welfare State Regimes: A Cluster Analysis." *International Journal of Social Welfare* 16, no. 4 (2007): 326-338.
- Barış, Enis, Salih Mollahaliloğlu, and Sabahattin Aydın. "Healthcare in Turkey: From Laggard to Leader." *BMJ* 342 (2011). Accessed August 14, 2016. doi: <http://dx.doi.org/10.1136/bmj.c7456>.
- Barnes, John Robert. *An Introduction to Religious Foundations in the Ottoman Empire*. Leiden: E.J. Brill, 1986.
- Başar, Dilek, Sarah Brown, and Arne Risa Hole. "Out-of-Pocket Healthcare Expenditure in Turkey: Analysis of the Household Budget Surveys 2002-2008." Sheffield Economic Research Paper Series 2012020, University of Sheffield, 2012. Accessed August 14, 2016. http://www.sheffield.ac.uk/polopoly_fs/1.209843!/file/serps_2012020.pdf.
- Bianchi, Robert. *Interest Groups and Political Development in Turkey*. Princeton, NJ: Princeton University Press, 1984.
- Bislev, Sven. "European Welfare States: Mechanisms of Convergence and Divergence." EUI Working Paper: RSC 24, European University Institute, 1997.
- Blank, Robert H., and Viola Burau. *Comparative Health Policy*. Basingstoke: Palgrave Macmillan, 2007.

- Balsler, Noah, and Aaron Stein. "The PKK's Urban Warfare Tactics." Atlantic Council. February 9, 2016. Accessed August 14, 2016. <http://www.atlanticcouncil.org/blogs/menasource/the-pkk-s-urban-warfare-tactics>.
- Blome, Agnes, Wolfgang Keck, and Jens Alber. *Family and the welfare state in Europe: Intergenerational relations in ageing societies*. Cheltenham: Edward Elgar Publishing, 2009.
- Boratav, Korkut. "Inter-Class and Intra-Class Relations of Distribution under 'Structural Adjustment': Turkey during the 1980s." In *The Political Economy of Turkey. Debt, Adjustment and Sustainability*, edited by Tosun Arıcanlı, and Dani Rodrik, 199-229. Basingstoke: Palgrave Macmillan, 1990.
- Bouquet, Denis. "Convergence in the Social Welfare Systems in Europe: From Goal to Reality." *Social Policy & Administration* 37, no. 6 (2003): 674-693.
- Buğra, Ayşe. "Poverty And Citizenship: An Overview of the Social-Policy Environment in Republican Turkey." *International Journal of Middle East Studies* 39, no. 1 (2007): 32-52.
- Buğra, Ayşe, and Ayşen Candaş. "Change and Continuity Under an Eclectic Social Security Regime: The Case of Turkey." *Middle Eastern Studies* 47, no. 3 (2011): 515-528.
- Buğra, Ayşe, and Çağlar Keyder. "Poverty and Social Policy in Contemporary Turkey." Boğaziçi University Social Policy Forum. January 2005. Accessed August 14, 2016. <http://www.spf.boun.edu.tr/docs/WP-Bugra-Keyder.pdf>.
- Buğra, Ayşe, and Çağlar Keyder. "The Turkish Welfare Regime in Transformation." *Journal of European Social Policy* 16, no. 3 (2006): 211-228.
- Buğra, Ayşe, and Osman Savaşkan. *New Capitalism in Turkey: The Relationship Between Politics, Religion and Business*. Cheltenham: Edward Elgar Publishing, 2014.
- Buğra, Ayşe, and Burcu Yakut-Çakar. "Structural Change, the Social Policy Environment and Female Employment in Turkey." *Development and Change* 41, no. 3 (2010): 517-538.
- Bureau, Viola, and Robert H. Blank. "Comparing Health Policy: An Assessment of Typologies of Health Systems." *Journal of Comparative Policy Analysis* 8, no. 1 (2006): 63-76.
- Buhr, Petra, and Sebastian Klinke. "Qualitative Folgen Der DRG-Einführung Für Arbeitsbedingungen Und Versorgung Im Krankenhaus Unter Bedingungen Fortgesetzter Budgetierung Eine Vergleichende Auswertung Von Vier Fallstudien." Discussion Paper 311, Wissenschaftszentrum Berlin für Sozialforschung Berlin, 2006.
- Busse, Reinhard, and Miriam Blümel. "Germany. Health System Review." *Health Systems in Transition* 16, no. 2, European Observatory on Health Systems and Policies, 2014.
- Busse, Reinhard, and Annette Riesberg. *Healthcare Systems in Transition: Germany*. Copenhagen: World Health Organization Regional Office for Europe, 2004.
- Cacace, Mirella I., Ralf Götze, Achim Schmid, and Heinz Rothgang. "Explaining Convergence and Common Trends in the Role of the State in OECD Healthcare Systems." *Harvard Health Policy Review* 9, no. 1 (2008): 5-16.

- Carinci, F., K. Van Gool, J. Mainz, J. Veillard, E. C. Pichora, J. M. Januel, I. Arispe, S. M. Kim, and N. S. Klazinga. "Towards Actionable International Comparisons of Health System Performance: Expert Revision of the OECD Framework and Quality Indicators." *International Journal for Quality in Healthcare* 27, no. 2 (2015): 137-146.
- Castles, Francis G., Stephan Leibfried, Jane Lewis, Herbert Obinger, and Christopher Pierson. Introduction to *The Oxford Handbook of the Welfare State*, edited by Francis G. Castles, Stephan Leibfried, Jane Lewis, Herbert Obinger, and Christopher Pierson, 1-18. Oxford: Oxford University Press, 2010.
- Cerny, Philip G. "Restructuring the Political Arena: Globalization and the Paradoxes of the Competition State." In *Globalization and its Critics. Perspectives from Political Economy*, edited by Randall D. Germain, 117-138. Basingstoke: Palgrave Macmillan, 2000.
- Ceyhan, Mehmet. "Recent Improvements in the Turkish Childhood National Immunization Program." *The Turkish Journal of Pediatrics* 52, no. 6 (2010): 563-569.
- Chernichovsky, Dov. "Health System Reforms in Industrialized Democracies: An Emerging Paradigm." *The Milbank Quarterly* 73, no. 3 (1995): 339-372.
- Cichon, Michael, William Newbrander, Hiroshi Yamabana, Axel Weber, Charles Normand, David Dror, and Alexander Preker. *Modelling in Healthcare Finance. A Compendium of Quantitative Techniques for Healthcare Financing*. Geneva: International Labour Office, 1999.
- Cizre Sakalioğlu, Ümit, and Erinc Yeldan. "Politics, Society and Financial Liberalization: Turkey in the 1990s." *Development and Change* 31, no. 2 (2000): 481-508.
- Collier, Ruth Berins, and David Collier. *Shaping the Political Arena: Critical Junctures, the Labor Movement, and Regime Dynamics in Latin America*. Princeton, NJ: Princeton University Press, 1991.
- Corke, Susan, Andrew Finkel, David J. Kramer, Carla Anne Robbins, and Nate Schenkkan. *Democracy in Crisis: Corruption, Media, and Power in Turkey*. A Freedom House Special Report, Washington D.C., New York, 2014. Accessed August 14, 2016. <https://freedomhouse.org/sites/default/files/Turkey%20Report%20-%20Feb%203,%202014.pdf>.
- Cutright, Phillips. "Political Structure, Economic Development, and National Social Security Programs." *American Journal of Sociology* 70, no. 5 (1965): 537-550.
- Czada, Roland. "Traditionslinien wohlfahrtsstaatlicher Politik." In *Regierungssystem und Regierungslehre. Fragestellungen, Analysekonzepte und Forschungsstand eines Kernbereichs der Politikwissenschaft*, edited by Stephan von Bandemer, and Göttrik Wewer, 275-287. Wiesbaden: Springer, 1989.
- Çarkoğlu, Ali. "Riding the Electoral Roller Coaster in Turkey: How to Read the Results of the June and November 2015 Elections?" *Global Turkey in Europe, Commentary* 28, December 2015. Accessed August 14, 2016. http://www.iai.it/sites/default/files/gte_c_28.pdf.
- Çarkoğlu, Ali, and Ersin Kalaycıoğlu. *Turkish Democracy Today*. New York: I.B.Tauris, 2007.

- Çatak, Binali, Can Öner, Mehmet Gülay, Sevgi Baştürk, İrfan Oğuz, and Resul Özbek. "Doğum öncesi bakım hizmetlerinin sahada izlemi ve değerlendirilmesi: Bursa örneği." *Türkiye Aile Hekimliği Dergisi* 18, no. 2 (2014): 63-69.
- Çelik, Yusuf. "The Socio-Economic Determinants of Alternative Sources of Antenatal Care in Turkey." *The International Journal of Health Planning and Management* 15, no. 3 (2000): 221-235.
- Çoban, Mustafa, Afsun Ezel Esatoğlu, and Mustafa Cumhur İzgi. "Türkiye'de evde sağlık ve bakım hizmetleri uygulamalarının mevzuat içindeki tarihsel değişimi." *Türkiye Biyoetik Dergisi* 1, no. 3 (2014): 154-176.
- Dahl, Robert A. "The Behavioral Approach in Political Science: Epitaph for a Monument to a Successful Protest." *American Political Science Review* 55, no. 4 (1961): 763-772.
- Daly, Mary, and Jane Lewis. "The Concept of Social Care and the Analysis of Contemporary Welfare States." *The British Journal of Sociology* 51, no. 2 (2000): 281-298.
- Deleon, Peter, and Phyllis Resnick-Terry. "Comparative Policy Analysis: Déjà Vu All Over Again?." *Journal of Comparative Policy Analysis: Research and Practice* 1, no. 1 (1998): 9-22.
- Deloitte Türkiye, and Uluslararası Yatırımcılar Derneği. *Türkiye sağlık sektörü raporu*. 2012. Accessed August 14, 2016. http://www.ahd.org.tr/Upload/Document/document_YASED_Saglik_Sektoru_Raporu_2013_02_18_15_02_07.pdf.
- Demirci, Tuba, and Selçuk Akşin Somel. "Women's Bodies, Demography, and Public Health: Abortion Policy and Perspectives in the Ottoman Empire of the Nineteenth Century." *Journal of the History of Sexuality* 17, no. 3 (2008): 377-420.
- Devlet Planlama Teşkilatı. *Birinci Beş Yıllık Kalkınma Planı (1963-1967)*. Ankara, 1963.
- Dinç, Cüneyd. *Sozialstaat als Produkt einer Staatselite. Die Türkei im südeuropäischen Vergleich*. Wiesbaden: VS Verlag für Sozialwissenschaften, 2009.
- Donatini, Andrea, Ana Rico, Maria Guiseppina D'Ambrosio, Alessandra Lo Scalzo, Letizia Orzella, Americo Cicchetti, and Silvia Profili. "Italy. 2001." *Health Systems in Transition* 3, no. 4, European Observatory on Health Systems, 2001.
- Dorlach, Tim. "The Political Economy of Pharmaceutical Prices: The Case of Turkey, 2002-2012." Master's Thesis. Boğaziçi University, 2013.
- Duben, Alan. "Generations of Istanbul Families, the Elderly, and the Social Economy of Welfare." *New Perspectives on Turkey* 48 (2013): 5-54.
- Duran, Burhanettin. "JDP and Foreign Policy as an Agent of Transformation." In *The Emergence of a New Turkey: Democracy and the AK Parti*, edited by M. Hakan Yavuz, 281-305. Salt Lake City: University of Utah Press, 2006.
- Duran, Burhanettin. "The Justice and Development Party's 'New Politics': Steering Toward Conservative Democracy, a Revised Islamic Agenda or Management of New Crises?." In *Secular*

- and Islamic Politics in Turkey. *The Making of the Justice and Development Party*, edited by Ümit Cizre, 80-106. Abingdon: Routledge 2008.
- Eckstein, Harry. *Pressure Group Politics: The Case of the British Medical Association*. Palo Alto: Stanford University Press, 1960.
- Eder, Mine. "Deepening Neoliberalisation and a Changing Welfare Regime in Turkey. Mutations of a Populist, "Sub-Optimal" Democracy." In *Turkey's Democratization Process*, edited by Carmen Rodriguez, Antonio Avalos, Hakan Yılmaz, and Ana I. Planet, 195-220. Abingdon: Routledge, 2013.
- Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü. *Engelli ve Yaşlı Bireylere İlişkin İstatistik Bilgiler. Yıllık İstatistik Bülteni 2015*. Ankara: Araştırma Geliştirme ve Proje Dairesi Başkanlığı, 2015.
- Erdal, Yavuz. "The State of the Industrial Workforce, 1923-40." In *Workers and the Working Class in the Ottoman Empire and the Turkish Republic: 1839-1950*, edited by Donald Quataert, and Erik Jan Zürcher, 95-126. New York: IB Tauris, 1995.
- Eroğlu, Şebnem. *Beyond the Resources of Poverty: Gecekondu Living in the Turkish Capital*. Farnham: Ashgate Publishing, 2011.
- Erus, Burcay, and Nazlı Aktakke. "Impact of Healthcare Reforms on Out-of-Pocket Health Expenditures in Turkey for Public Insurees." *The European Journal of Health Economics* 13, no. 3 (2012): 337-346.
- Erus, Burcay, Burcu Yakut-Çakar, Sanda Cali, and Fikret Adaman. "Health Policy for the Poor: An Exploration on the Take-Up of Means-Tested Health Benefits in Turkey." *Social Science & Medicine* 130 (2015): 99-106.
- Esen, Berk, and Şebnem Gümüşçü. "Rising Competitive Authoritarianism in Turkey." *Third World Quarterly* 37, no. 9 (2016): 1-26.
- Eskiocak, Muzafer. *Kentsel Bölgede Sağlık Örgütlenmesi: Çok Sektörlü Yaklaşım. Aile Hekimliği Ülkemiz için Uygun Bir Model midir?*. Ankara: Türk Tabipleri Birliği Merkez Konseyi, 2007. Accessed August 14, 2016. https://www.ttb.org.tr/kutuphane/kentlerde_saglik_hizmetleri2.pdf.
- Esping-Andersen, Gøsta. *Politics Against Markets: The Social Democratic Road to Power*. Princeton: Princeton University Press, 1985.
- Esping-Andersen, Gøsta. *The Three Worlds of Welfare Capitalism*. Cambridge: Polity Press, 1990.
- Esping-Andersen, Gøsta. "Towards the Good Society, Once Again?." In *Why We Need a New Welfare State*, edited by Gøsta Esping-Andersen, 1-25. Oxford: Oxford University Press, 2002.
- Etiler, Nilay. "Neoliberal Politikalar ve Sağlık Emekgücü Üzerindeki Etkileri." *Türk Tabipler Birliği Mesleki Sağlık ve Güvenlik Dergisi* 42 (2011): 2-11.
- European Observatory on Health Care Systems. *Health Care Systems in Transition. Germany. 2000*. Copenhagen, 2000.

- European Stability Initiative. *Islamic Calvinists: Change and Conservatism in Central Anatolia*. Berlin and Istanbul, September 2005. Accessed August 14, 2016. http://www.esiweb.org/pdf/esi_document_id_69.pdf.
- Evers, Adalbert, and Helmut Wintersberger. *Shifts in the Welfare Mix. Their Impact on Work, Social Services and Welfare Policies*. Frankfurt: Campus, 1990.
- Evren, Yiğit, and Ayşe Nur Ökten. "Family Solidarity and Place as Components of Hospital Provision in Istanbul: The Dependence of Public Healthcare on Culture and the Local Economy." *International Planning Studies* 16, no. 1 (2011): 97-108.
- Field, Mark G. "The Concept of the "Health System" at the Macrosociological Level." *Social Science & Medicine* 7, no. 10 (1973): 763-785.
- Field, Mark G. "The Health System and the Polity: A Contemporary American Dialectic." *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology* 14, no. 5 (1980): 397-413.
- Field, Mark G. "The Comparative Evolution of Health Systems: Convergence, Diversity and Cross-Cutting Issues." In *Health and Illness in America and Germany. Gesundheit und Krankheit in der BRD und den USA*, edited by Günther Lüschen, William C. Cockerham, and Gerhard Kunz, 15-30. München: de Gruyter Oldenbourg, 1989.
- Filiztekin, Alpay, and İnsan Tunalı. "Anatolian Tigers: Are They for Real?." *New Perspectives on Turkey* 20 (1999): 77-106.
- Finch, Janet, and Dulcie Groves, eds. *A Labour of Love: Women, Work, and Caring*. Abingdon: Routledge, 1983.
- Findley, Carter V. *Bureaucratic Reform in the Ottoman Empire: The Sublime Porte. 1789-1922*. Princeton: Princeton University Press, 1980.
- Findley, Carter V. *Turkey, Islam, Nationalism, and Modernity: A History, 1789-2007*. New Haven: Yale University Press, 2010.
- Fişek, A. Gürhan, Şerife Türcan Özsuca, and Mehmet Ali Şuğle. *Sosyal Sigortalar Kurumu Tarihi 1946–1996*. Ankara: Sosyal Sigortalar Kurumu, 1998.
- Flora, Peter, and Jens Alber. "Modernization, Democratization, and the Development of Welfare States in Western Europe." In *The development of welfare states in Europe and America*, edited by Peter Flora, and Arnold Joseph Heidenheimer, 37-80. New Brunswick: Transaction Books, 1981.
- Fraser, Nancy. "After the Family Wage: Gender Equity and the Welfare State." *Political Theory* 22, no. 4 (1994): 591-618.
- Freeman, Richard. *The Politics of Health in Europe*. Manchester University Press, 2000.
- Freeman, Richard, and Heinz Rothgang. "Health." In *The Oxford Handbook of the Welfare State*, edited by Francis G. Castles, Stephan Leibfried, Jane Lewis, Herbert Obinger, and Christopher Pierson, 367-377. Oxford: Oxford University Press, 2010.

- Freidson, Eliot L. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago: University of Chicago Press, 1970.
- Fuhrmann, Malte. "Das deutsche Krankenhaus." In *Deutsche Präsenz am Bosphorus*, edited by Matthias von Kummer, 257-270. Istanbul: Zero Books, 2009.
- Ghai, Dharam. Foreword to *Welfare States in Transition. National Adaptations in Global Economies*, edited by Gøsta Esping-Andersen, vii-ix. Thousand Oaks: SAGE Publications, 1997.
- Giaimo, Susan, and Philip Manow. "Adapting the Welfare State. The Case of Healthcare Reform in Britain, Germany, and the United States." *Comparative Political Studies* 32, no. 8 (1999): 967-1000.
- Göçmen Yeginoğlu, İpek. "The Politics of Religiously Motivated Welfare Provision." Doctoral Dissertation. Cologne University, 2010.
- Gough, Ian. "Social Assistance in Southern Europe." *South European Society & Politics* 1, no. 1 (1996): 1-23.
- Gough, Ian, and Geof Wood. Introduction to *Insecurity and Welfare Regimes in Asia, Africa and Latin America. Social Policy in Developmental Contexts*, edited by Ian Gough, and Geof Wood, 1-11. Cambridge: Cambridge University Press, 2004.
- Grigoryan, Larissa, Flora M. Haaijer-Ruskamp, Johannes G.M. Burgerhof, Reli Mechtler, Reginald Deschepper, Arjana Tambic-Andrasevic, Retnosari Andrajati, Dominique L. Monnet, Robert Cunney, Antonella Di Matteo, Hana Edelstein, Rolanda Valinteliene, Alaa Alkerwi, Elizabeth A. Scicluna, Pawel Grzesiowski, Ana-Claudia Bara, Thomas Tesar, Milan Cizman, Jose Campos, Cecilia Stålsby Lundborg, and Joan Birkin. "Self-medication with antimicrobial drugs in Europe." *Emerging Infectious Diseases* 12, no. 3 (2006): 452-459.
- Grimmeisen, Simone, and Lorraine Frisina. "The Role of the State in the British Healthcare System. Between Marketization and Statism." In *The State and Healthcare: Comparing OECD Countries*, edited by Heinz Rothgang, Mirella Cacace, Simone Grimmeisen, Uwe Helmert, and Claus Wendt, 75-118. Basingstoke: Palgrave Macmillan, 2010.
- Grütjen, Daniel. "The Turkish Welfare Regime: An Example of the Southern European Model? The Role of the State, Market and Family in Welfare Provision." *Turkish Policy Quarterly* 7, no. 1 (2008): 111-129.
- Güldal, Dilek, Betül Öner, and Semih Şemin. "Hastanelerde Neden Refakatçi Kalıyorlar?." *Türkiye Aile Hekimliği Dergisi* 5, no. 1-4 (2001): 18-21.
- Günel, Asena. "Health and Citizenship in Republican Turkey: An Analysis of the Socialization of Health Services in Republican Historical Context." PhD Dissertation. Boğaziçi University, 2008.
- Günergun, Feza, and Şeref Etker. "Waqf Endowments and the Emergence of Modern Charitable Hospitals in the Ottoman Empire." In *The Development of Modern Medicine in Non-western Countries: Historical Perspectives*, edited by Hormoz Ebrahimnejad, 82-107. London: Routledge, 2009.

- Gürsel, Kadri. "Turkey's failed coup reveals 'army within an army'." *Al-Monitor*, July 22, 2016. Accessed August 14, 2016. <http://www.al-monitor.com/pulse/originals/2016/07/turkey-coup-attempt-shows-army-within-army.html>.
- Gürsel, Seyfettin, Burak Darbaz, and Ulaş Karakoç. "Green Card: Successes and Failures of the Most Expensive Social Policy Program in Turkey." Research Brief 09/39, Center For Economic and Social Research (BETAM), June 2009. Accessed August 14, 2016. <http://betam.bahcesehir.edu.tr/wp-content/uploads/2015/06/ResearchBrief039.pdf>.
- Haberecht, Christian. *Bildungspolitik als Sozialpolitik: Ein deutsch-britischer Vergleich des Third Way*. Schwalbach am Taunus: Wochenschau Verlag, 2015.
- Hacker, Jacob S. "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and US Medical Policy." *Studies in American Political Development* 12, no. 1 (1998): 57-130.
- Hall, Peter A. "Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain." *Comparative Politics* 25, no. 3 (1993): 275-296.
- Hall, Peter A., and Rosemary C.R. Taylor. "Political Science and the Three New Institutionalisms." *Political Studies* 44, no. 5 (1996): 936-957.
- Ham, Chris. *Healthcare Reform: Learning From International Experience*. Buckingham: Open University Press, 1997.
- Haraway, Donna Jeanne. *Primate Visions: Gender, Race, and Nature in the World of Modern Science*. Oxford: Psychology Press, 1989.
- Harrison, Stephen, and Maggie Mort. "Which Champions, Which People? Public and User Involvement in Healthcare as a Technology of Legitimation." *Social Policy & Administration* 32, no. 1 (1998): 60-70.
- Haug, Marie R. "A Re-examination of the Hypothesis of Physician Deprofessionalization." *The Milbank Quarterly* 66 (1988): 48-56.
- Häusermann, Silja. *The Politics of Welfare State Reform in Continental Europe: Modernization in Hard Times*. Cambridge: Cambridge University Press, 2010.
- Hecló, Hugh. *Modern Social Politics in Britain and Sweden: From Relief to Income Maintenance*, New Haven: Yale University Press, 1974.
- Held, David, Anthony McGrew, David Goldblatt, and Jonathan Perraton. Introduction to *Global Transformations. Politics, Economics, and Culture*, edited by David Held, Anthony McGrew, David Goldblatt, and Jonathan Perraton, 1-7. Palo Alto: Stanford University Press, 1999.
- Heper, Metin: "The Ottoman Legacy and Turkish Politics." *Journal of International Affairs* 54, no. 1 (2000): 63-82.
- Héritier, Adrienne, and Sandra Eckert. "New Modes of Governance in the Shadow of Hierarchy: Self-Regulation by Industry in Europe." *Journal of Public Policy* 28, no. 1 (2008): 113-138.

Héritier, Adrienne, and Dirk Lehmkuhl. "The Shadow of Hierarchy and New Modes of Governance." *Journal of Public Policy* 28, no. 1 (2008): 1-17.

Hillmann, Felicitas. "Migrants Care Work in Private Households, or the Strength of Bilocal and Transnational Ties as a Last(ing) Resource in Global Migration." In *Care and Social Integration in European Societies*, edited by Birgit Pfau-Effinger, and Birgit Geissler, 93-114. Bristol: Policy Press at the University of Bristol, 2005.

Hirschman, Albert O. "The Political Economy of Import-Substituting Industrialization in Latin America." *The Quarterly Journal of Economics* 82, no. 1 (1968): 1-32.

Huber, Evelyne, and John D. Stephens. *Development and Crisis of the Welfare State: Parties and Policies in Global Markets*. Chicago: University of Chicago Press, 2001.

Hurst, Jeremy W. "Reforming Healthcare in Seven European Nations." *Health Affairs* 10, no. 3 (1991): 7-21.

Immergut, Ellen M. *Health Politics: Interests and Institutions in Western Europe*. Cambridge: Cambridge University Press, 1992.

Immergut, Ellen M. "The Theoretical Core of the New Institutionalism." *Politics and Society* 26 (1998): 5-34.

İlhan, Mustafa N., Elif Durukan, Sevil Özger İlhan, F. Nur Aksakal, Seçil Özkan, and Mehmet Ali Bumin. "Self-Medication With Antibiotics: Questionnaire Survey Among Primary Care Center Attendants." *Pharmacoepidemiology and Drug Safety* 18, no. 12 (2009): 1150-1157.

İlkan, Ceren Gülser. "Tuberculosis, Medicine and Politics. Public Health in the Early Republican Turkey." Master's Thesis, Boğaziçi University, 2006.

İnalçık, Halil, and Donald Quataert. *An Economic and Social History of the Ottoman Empire, 1600-1914*. Cambridge: Cambridge University Press, 1997.

İşikli, Alpaslan. "Wage Labor and Unionization." In *Turkey in Transition: New Perspective*, edited by Irvin Schick, and Ertugrul Ahmet Tonak, 309-332. Oxford: Oxford University Press, 1987.

Jawad, Rana, and Burcu Yakut-Çakar. "Religion and Social Policy in the Middle East: The (Re)Constitution of an Old-New Partnership." *Social Policy & Administration* 44, no. 6 (2010): 658-672.

Jensen, Carsten. "Worlds of Welfare Services and Transfers." *Journal of European Social Policy* 18, no. 2 (2008): 151-162.

Joppien, Charlotte. *Die türkische Adalet ve Kalkınma Partisi (AKP)*. Berlin: Klaus Schwarz Verlag, 2010.

Kalaycıoğlu, Ersin. *Turkish Dynamics. Bridges across Troubled Lands*. Basingstoke: Palgrave Macmillan, 2005.

Kalaycıoğlu, Sibel. "Dynamics of Poverty in Turkey: Gender, Rural/Urban Poverty, Social Networks and Reciprocal Survival Strategies." In *Poverty and Social Deprivation in the Mediterranean Area*:

- Trends, Policies and Welfare Prospects in the New Millennium*, edited by Maria Petmesidou, and Christos Papatheodorou, 218-247. London: Zed Books, 2006.
- Kalaycıoğlu, Sibel, and Helga Rittersberger-Tılıç. "Intergenerational Solidarity Networks of Instrumental and Cultural Transfers within Migrant Families in Turkey." *Ageing and Society* 20, no. 5 (2000): 523-542.
- Kalkan, İbrahim Halil. "Medicine and Politics in the Late Ottoman Empire (1876-1909)." Master's Thesis, Boğaziçi University, 2004.
- Karabağ, Hüseyin. "Evde sağlık bakım hizmetlerinin Türkiye'de uygulanabilirliğine ilişkin hekimlerin görüşleri ve kardiyoloji hastaları için hastane destekli evde bakım hizmetleri model önerisi." Master's Thesis. Gazi Üniversitesi Ankara, 2007.
- Kasza, Gregory J. "The Illusion of Welfare 'Regimes'." *Journal of Social Policy* 31, no. 2 (2002): 271-287.
- Keyder, Çağlar. *State and Class in Turkey: A Study in Capitalist Development*. London: Verso, 1987.
- Keyder, Çağlar, and Ayşe Buğra. "New Poverty and the Changing Welfare Regime of Turkey." UNDP Ankara, 2003.
- Keyder, Çağlar, and Ayşe Öncü. *Istanbul and the Concept of World Cities*, Istanbul: Friedrich Ebert Foundation, 1993.
- Keyman, E. Fuat. "The Post-Elections Turkey: What Lies Ahead?." *Global Turkey in Europe*, Commentary 27, November 2015. Accessed August 14, 2016. http://www.iai.it/sites/default/files/gte_c_27.pdf.
- Keyman, E. Fuat., and Ziya Öniş. *Turkish Politics in a Changing World: Global Dynamics and Domestic Transformations*. Istanbul: Istanbul Bilgi University Press, 2007.
- Kılıç, Azer. "The Gender Dimension of Social Policy Reform in Turkey: Towards Equal Citizenship?." *Social Policy & Administration* 42, no. 5 (2008): 487-503.
- Knijn, Trudie, and Monique Kremer. "Gender and the Caring Dimension of Welfare States: Toward Inclusive Citizenship." *Social Politics: International Studies in Gender, State & Society* 4, no. 3 (1997): 328-361.
- Kollak, Ingrid. *Internationale Modelle häuslicher Pflege. Eine Herausforderung und verschiedene Antworten*. Frankfurt am Main: Mabuse, 2001.
- Korpi, Walter. *The Democratic Class Struggle*. Abingdon: Routledge, 1983.
- Korpi, Walter. "Power, Politics, and State Autonomy in the Development of Social Citizenship: Social Rights During Sickness in Eighteen OECD Countries Since 1930." *American Sociological Review* 54, no. 3 (1989): 309-328.
- Korpi, Walter, and Joakim Palme. "New Politics and Class Politics in the Context of Austerity and Globalization: Welfare State Regress in 18 Countries, 1975-95." *American Political Science Review* 97, no. 3 (2003): 425-446.

- Kringos, Dionne S., Wienke G.W. Boerma, Ernst Spaan, and Martina Pellny. "A Snapshot of the Organization and Provision of Primary Care in Turkey." *BMC Health Services Research* 11 (2011). Accessed August 14, 2016. <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-11-90>.
- Kröger, Teppo. *Comparative Research on Social Care: The State of the Art*. SOCCARE Project Report 1, European Commission, 2001. Accessed August 14, 2016. <http://cordis.europa.eu/documents/documentlibrary/90834291EN6.pdf>.
- Kuhlmann, Ellen, and Viola Burau. "The 'Healthcare State' in Transition: National and International Contexts of Changing Professional Governance." *European Societies* 10, no. 4 (2008): 619-633.
- Kultu, Zümray. *From the Ante-Chamber to the Living Room: A Brief Assessment on NGO's Doing Work for Syrian Refugees*. Istanbul: Anadolu Kültür and Open Society Foundations (2015). Accessed August 14, 2016. http://www.anadolukultur.org/images/UserFiles/Documents/Editor/From_The_Ante_Chamber_to_the_Living_Room.pdf.
- Kumbaracıbaşı, Arda Can. *Turkish Politics and the Rise of the AKP: Dilemmas of Institutionalization and Leadership Strategy*. Abingdon: Routledge, 2009.
- Langan, Mary, and Ilona Ostner. "Gender and Welfare: Towards a Comparative Framework." In *Towards a European Welfare State*, edited by Graham Room, 127-150. Bristol: SAUS, 1991.
- Lascombes, Pierre, and Patrick Le Galès. "Introduction: Understanding Public Policy through Its Instruments - From the Nature of Instruments to the Sociology of Public Policy Instrumentation." *Governance* 20, no. 1 (2007): 1-21.
- Le Galès, Patrick. "Policy Instruments and Governance." In *The SAGE Handbook of Governance*, edited by Mark Bevir, 142-159. Thousand Oaks: SAGE, 2011.
- Lewis, Bernard. *The Emergence of Modern Turkey*. Oxford: Oxford University Press, 1961.
- Lewis, Jane. "Gender and Welfare Regimes: Further Thoughts." *Social Politics: International Studies in Gender, State & Society* 4, no. 2 (1997): 160-177.
- Lewis, Jane. "Work/Family Reconciliation, Equal Opportunities and Social Policies: The Interpretation of Policy Trajectories at the EU Level and the Meaning of Gender Equality." *Journal of European Public Policy* 13, no. 3 (2006): 420-437.
- Lewis, Jane, and Susanna Giullari. "The Adult Worker Model Family, Gender Equality and Care: The Search for New Policy Principles and the Possibilities and Problems of a Capabilities Approach." *Economy and Society* 34, no. 1 (2005): 76-104.
- Lewis, Jane, and Barbara Meredith. *Daughters Who Care: Daughters Caring for Mothers at Home*. Abingdon: Routledge, 1988.
- Lewis, Jane, and Ilona Ostner. "Gender and the Evolution of European Social Policies." ZeS-Arbeitspapier, Zentrum für Sozialpolitik Bremen, 1994.

Lister, Ruth. "Citizenship: Towards a Feminist Synthesis." *Feminist Review* 57, no. 1 (1997): 28-48.

Liu, Yuanli, Yusuf Çelik, and Bayram Şahin. *Healthcare/Pharmaceutical Spending and Pharmaceutical Reimbursement Policy in Turkey*. Ankara: Hope in Health Foundation (SUVAK), September 2005. Accessed August 14, 2016. <http://www.pharmine.org/wp-content/uploads/2014/05/Healthcare-and-Pharmaceutical-Spending-in-Turkey.pdf>.

Majone, Giandomenico. "From the Positive to the Regulatory State: Causes and Consequences of Changes in the Mode of Governance." *Journal of Public Policy* 17, no. 2 (1997): 139-167.

Mango, Andrew. *The Turks Today*. New York: Overlook Press, 2004.

Marmor, Theodore, Richard Freeman, and Kieke Okma. "Comparative Perspectives and Policy Learning in the World of Healthcare." *Journal of Comparative Policy Analysis: Research and Practice* 7, no. 4 (2005): 331-348.

Marmor, Theodore, and Claus Wendt. "Conceptual Frameworks for Comparing Healthcare Politics and Policy." *Health Policy* 107, no. 1 (2012): 11-20.

Marshall, Thomas H. *Citizenship and Social Class*. Cambridge: Cambridge University Press, 1950.

Mayntz, Renate. "Von der Steuerungstheorie zu Global Governance." In *Governance in einer sich wandelnden Welt*, edited by Gunnar Folke Schuppert, and Michael Zürn, 43-60. Wiesbaden: Springer VS, 2008.

Mayntz, Renate, and Fritz W. Scharpf. "Der Ansatz des akteurzentrierten Institutionalismus." In *Gesellschaftliche Selbstregulierung und politische Steuerung*, edited by Renate Mayntz, and Fritz W. Scharpf, 39-72. Frankfurt: Campus Verlag, 1995.

Mayntz, Renate, and Fritz W. Scharpf. "Anhang. Politische Steuerung—Heute?." *Zeitschrift für Soziologie* 34, no. 3 (2005): 236-243.

McKee, Martin, and Judith Healy, eds. *Hospitals in a Changing Europe*. Buckingham: Open University Press, 2002.

Mello, Brian. "(Re)Considering the Labor Movement in Turkey." *European Journal of Turkish Studies* 11, no. 1 (2010): 2-7.

Menon, Rekha, Salih Mollahaliloğlu, and Iryna Postolovska. "Toward Universal Coverage: Turkey's Green Card Program for the Poor." UNICO Studies Series no. 18, World Bank, 2013. Accessed August 14, 2016. <http://documents.worldbank.org/curated/en/565451468319153981/pdf/750120NWP0Box300for0the0Poor0TURKEY.pdf>.

Ministry of Health of the Turkish Republic. *Türkiye Sağlık Harcamaları ve Finansmanı 1997*. Ankara: Sağlık Projesi Genel Koordinatörlüğü, 2001. (2001a):

Ministry of Health of the Turkish Republic. *Türkiye Sağlık Harcamaları ve Finansmanı 1998*. Ankara: Sağlık Projesi Genel Koordinatörlüğü, 2001. (2001b).

- Ministry of Health of the Turkish Republic. *Transformation in Health*. Ankara, 2003
- Ministry of Health of the Turkish Republic. *Turkey National Health Accounts 1999-2000*. Ankara: Refik Saydam Hygiene Center, School of Public Health, 2004.
- Ministry of Health of the Turkish Republic. *Turkey Health Transformation Program. Assessment Report (2003-2011)*. Ankara, 2012.
- Ministry of Health of the Turkish Republic. *Sağlık İstatistikleri Yıllığı. 2013*. Ankara: Sağlık Araştırmaları Genel Müdürlüğü, 2014.
- Ministry of Health of the Turkish Republic. *Türkiye. Sağlıklı Yaşlanma Eylem Planı ve Uygulama Programı 2015-2020*. Ankara: Halk Sağlığı Kurumu, 2015.
- Misra, Joya, and Stephanie Moller. "Familialism and Welfare Regimes: Poverty, Employment, and Family Policies." LIS Working Paper Series, no. 399, 2005. Accessed August 14, 2016. <https://www.econstor.eu/bitstream/10419/95502/1/483132357.pdf>.
- Moran, Michael. *Governing the Healthcare State: A Comparative Study of the United Kingdom, the United States, and Germany*. Manchester: Manchester University Press, 1999.
- Moran, Michael. "Understanding the Welfare State: The Case of Healthcare." *The British Journal of Politics and International Relations* 2, no. 2 (2000): 135-160.
- Müftüler-Baç, Meltem. "Turkish Foreign Policy Change, its Domestic Determinants and the Role of the European Union." *South East European Politics and Society* 16, no. 2 (2011): 279-291.
- Müftüler-Baç, Meltem, and Yannis A. Stivachtis. *Turkey-European Union Relations: Dilemmas, Opportunities, and Constraints*. Lanham, MD: Lexington Books, 2008.
- Navarro, Vicente. "Why Some Countries Have National Health Insurance, Others Have National Health Services, and the US Has Neither." *Social Science & Medicine* 28, no. 9 (1989): 887-898.
- North, Douglass C. *Institutions, Institutional Change and Economic Performance*. Cambridge. Cambridge University Press, 1990.
- O'Connor, James. *The Fiscal Crisis of the State*. Piscataway: Transaction Publishers, 1973.
- Organisation for Economic Co-operation and Development. "Financing and Delivering Healthcare. A Comparative Analysis of OECD Countries." OECD Social Policy Studies no. 4, 1987.
- Organisation for Economic Co-operation and Development. *Economic Survey of Turkey, 2006*. OECD Policy Brief, October 2006.
- Organisation for Economic Co-operation and Development. *Financing of Healthcare, in Health at a Glance 2013: OECD Indicators*. OECD Publishing, 2013.
- Organisation for Economic Co-operation and Development. *Turkey 2014: Raising Standards*. OECD Reviews of Healthcare Quality, OECD Publishing, 2014.

- Organisation for Economic Co-operation and Development. *OECD Employment Outlook 2016*. OECD Publishing, 2016.
- Organisation for Economic Co-operation and Development, Eurostat, and World Health Organisation. *A System of Health Accounts*. OECD Publishing, 2011.
- Organisation for Economic Co-operation and Development, and World Bank. *Turkey*. OECD Reviews of Health Systems, 2008.
- Organisation for Economic Co-operation and Development, and World Health Organisation. *Guidelines for the Implementation of the SHA 2011 Framework*. OECD Health Division and WHO NHA Team, 2014.
- Orloff, Ann Shola. "Gender and the Social Rights of Citizenship: The Comparative Analysis of Gender Relations and Welfare States." *American Sociological Review* 58, no. 3 (1993): 303-328.
- Orloff, Ann Shola. "Farewell to Maternalism? State Policies and Mothers' Employment." In *The State After Statism*, edited by Jonah Levy, 230-268. Massachusetts: Harvard University Press, 2006.
- Orloff, Ann Shola. "Gendering the Comparative Analysis of Welfare States: An Unfinished Agenda." *Sociological Theory* 27, no. 3 (2009): 317-343.
- Owen, Roger, and Şevket Pamuk. *A History of Middle East Economies in the Twentieth Century*. New York: IB Tauris, 1998.
- Öcek, Zeliha Asli, Meltem Çiçeklioğlu, Ummahan Yücel, and Raziye Özdemir. "Family Medicine Model in Turkey: A Qualitative Assessment from the Perspectives of Primary Care Workers." *BMC Family Practice* 15, no. 38 (2014): 1-15.
- Öktem, Kerem. *Angry Nation. Turkey since 1989*. London: Zed Books, 2011.
- Öktem, Kerem. "Zombie politics: "Europe, Turkey and the Disposable Human." *Open Democracy*. March 19, 2016. Accessed August 14, 2016. <https://www.opendemocracy.net/kerem-oktem/zombie-politics-europe-turkey-and-disposable-human>.
- Öktem, Kerem, Ayşe Gülden Kadioğlu, and Mehmet Karli. *Another Empire? A Decade of Turkey's Foreign Policy Under the Justice and Development Party*. Istanbul: Istanbul Bilgi University Press, 2012.
- Öniş, Ziya. "Redemocratization and Economic Liberalization in Turkey: The Limits of State Autonomy." *Studies in Comparative International Development* 27, no. 2 (1992): 3-23.
- Öniş, Ziya. "Globalization and Party Transformation: Turkey's Justice and Development Party in Perspective." In *Globalizing Democracy: Party Politics in Emerging Democracies*, edited by Peter Burnell, 1-27. Abingdon: Routledge, 2006.
- Öniş, Ziya, and Ali Burak Güven. "Global Crisis, National Responses: The Political Economy of Turkish Exceptionalism." *New Political Economy* 16, no. 5 (2011): 585-608.

- Özar, Şemsa, and Burcu Yakut-Çakar. *Aile, Devlet ve Piyasa Kısacında Boşanmış Kadınlar*. Boğaziçi Üniversitesi Sosyal Politika Forumu, February 2012. Accessed August 14, 2016.
<http://www.spod.org.tr/turkce/wp-content/uploads/2013/06/%C3%96zar-ve-Yakut-%C3%87akar-Feminist-Yakla%C5%9F%C4%B1mlara-%C5%9Eubat-2012-2.pdf>.
- Özbek, Nadir. "The Politics of Poor Relief in the Late Ottoman Empire. 1876-1914." *New Perspectives on Turkey* 21 (1999): 1-33.
- Özbek, Nadir. "'Beggars' and 'Vagrants' in Ottoman State Policy and Public Discourse, 1876–1914." *Middle Eastern Studies* 45, no. 5 (2009): 783-801.
- Pamuk, Şevket. "Economic Change in the Twentieth-Century Turkey: Is the Glass More Than Half Full?." In *The Cambridge History of Turkey. Volume 4. Turkey in the Modern World*, edited by Reşat Kasaba, 266-300. Cambridge: Cambridge University Press, 2008.
- Pamuk, Şevket. "Globalization, Industrialization and Changing Politics in Turkey." *New Perspectives on Turkey* 38 (2008): 267-273.
- Paris, Valérie, Marion Devaux, and Lihan Wei. "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries." OECD Health Working Papers no. 50, OECD Publishing, 2010.
- Patton, Marcie J. "The Synergy between Neoliberalism and Communitarianism: Erdoğan's Third Way." *Comparative Studies in Africa, Asia and the Middle East* 29, no. 3 (2009): 438-449.
- Peri, Oded. "Waqf and Ottoman Welfare Policy. The Poor Kitchen of Hasseki Sultan in Eighteenth-Century Jerusalem." *Journal of Economic and Social History of the Orient* 35, no. 2 (1992): 167-186.
- Harrison, Stephen, and Maggie Mort. "Which Champions, Which People? Public and User Involvement in Healthcare as a Technology of Legitimation." *Social Policy & Administration* 32, no. 1 (1998): 60-70.
- Pierson, Paul. "The New Politics of the Welfare State." *World Politics* 48 (1996): 143-179.
- Pierson, Paul. "Three Worlds of Welfare State Research." *Comparative Political Studies* 33, no. 6-7 (2000): 791-821.
- Pierson, Paul. *Politics in Time: History, Institutions, and Social Analysis*. Princeton: Princeton University Press, 2004.
- Polanyi, Karl. *Origins of Our Time: The Great Transformation*. Boston, Massachusetts: Beacon Press, 1994.
- Porter, Dorothy. *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times*. Hove: Psychology Press, 1999.
- Powell, Martin A. Introduction to *Moderinising the Welfare State. The Blair Legacy*, edited by Martin A. Powell, 1-16. Bristol: Policy Press University of Bristol, 2008.

Prime Ministry of the Republic of Turkey. "The Silent Revolution Turkey's Democratic Change and Transformation Inventory 2002 - 2012." Undersecretariat of Public Order and Security Publications no. 7, Ankara, 2013.

Quataert, Donald. *The Ottoman Empire, 1700-1922*. Cambridge: Cambridge University Press, 2000.

Raffel, Marshall W., ed. *Healthcare and Reform in Industrialized Countries*. University Park, Pennsylvania: Pennsylvania State University Press, 2007.

Rechel, Bernd, Sarah Thomson, and Ewout van Ginneken. *Health Systems in Transition. Template for Authors*. Copenhagen: WHO Regional Office for Europe, 2010.

Rico, Ana, Richard B. Saltman, and Wienke G.W. Boerma. "Organizational Restructuring in European Health Systems: The Role of Primary Care." *Social Policy & Administration* 37, no. 6 (2003): 592-608.

Roemer, Milton Irwin. "Health Departments and Medical Care - A World Scanning." *American Journal of Public Health and the Nations Health* 50, no. 2 (1960): 154-160.

Roemer, Milton Irwin. *Comparative National Policies on Healthcare*. New York: Marcel Dekker Inc., 1977.

Rothgang, Heinz, Mirella Cacace, Simone Grimmeisen, and Claus Wendt. "The Changing Role of the State in Healthcare Systems." *European Review* 13 (2005): 187-212.

Rousseau, Jean-Jacques. *Politics and the Arts*. Ithaca: Cornell Press, 1993.

Saatçioğlu, Beken. "AKP's 'Europeanization' in Civilianization, Rule of Law and Fundamental Freedoms: The Primacy of Domestic Politics." *Journal of Balkan and Near Eastern Studies* 16, no. 1 (2014): 86-101.

Safran, William. *Veto-Group Politics: The Case of Health-Insurance Reform in West Germany*. Chandler Publications in Political Science, 1967.

Sainsbury, Diane. *Gender, Equality and Welfare States*. Cambridge: Cambridge University Press, 1996.

Sainsbury, Diane. *Gender and Welfare State Regimes*. Oxford: Oxford University Press, 1999.

Saka, Ömer, and Nebibe Varol. "Institutional and Community Care for Older People in Turkey." *Eurohealth* 13, no. 3 (2007): 20-22.

Saraceno, Chiara. *Social Assistance Dynamics in Europe: National and Local Poverty Regimes*. Bristol: Policy Press University of Bristol, 2002.

Sarı, Nil. "Educating the Ottoman Physician." Foundation for Science Technology and Civilisation, 4097, August 2005. Accessed August 14, 2016.
<http://www.muslimheritage.com/uploads/EducatingOttomanDoctors.pdf>.

Savaş, B. Serdar, Ömer Karahan, and R. Ömer Saka. "Turkey. 2002." *Healthcare Systems in Transition* 4, no. 4, European Observatory on Healthcare Systems, 2002.

- Schuppert, Gunnar Folke. "Zur Neubelebung der Staatsdiskussion: Entzauberung des Staates oder Bringing the State Back?." *Der Staat* 28, no. 1 (1989): 91-104.
- Schuppert, Gunnar Folke. "Was ist und wie misst man Wandel von Staatlichkeit?." *Der Staat* 47, no. 3 (2008): 325-358.
- Sen, Amartya K. *Development as Freedom*. Oxford: Oxford University Press, 1999.
- Shefer, Miri. "Old patterns, New Meaning: The 1845 Hospital of Bezm-i Alem in Istanbul." *Dynamis* 25 (2005): 329-50.
- Simonazzi, Annamaria. "Care Regimes and National Employment Models." *Cambridge Journal of Economics* 33, no. 2 (2009): 211-232.
- Skocpol, Theda. *States and Social Revolutions: A Comparative Analysis of France, Russia and China*. Cambridge: Cambridge University Press, 1979.
- Skocpol, Theda. "America's Incomplete Welfare State: The Limits of New Deal Reforms and the Origins of the Present Crisis." In *Stagnation and Renewal in Social Policy. The Rise and Fall of Policy Regimes*, edited by Martin Rein, Gøsta Esping-Andersen, and Lee Rainwater, 35-58. Armonk, London: M.E. Sharpe Inc., 1987.
- Sosyal Güvenlik Kurumu. "Sağlık Bakanlığı ve Bağlı Kuruluşları Tarafından Evde Sağlık Hizmetlerinin Sunulmasına Dair Yönetmelik." October 28, 2011.
- Sosyal Güvenlik Kurumu. *Performans Programı 2014*. Ankara: Strateji Geliştirme Başkanlığı, 2014.
- Sosyal Güvenlik Kurumu. Genelge. Tamamlayıcı veya Destekleyici Sağlık Sigortası Uygulamaları, no. B.13.2.SGK.0.11.05.03 /674, 2012/25, June 28, 2012. Accessed on August 14, 2016. http://www.sgk.gov.tr/wps/wcm/connect/42513bda-6eaa-4a3f-a257-239149e51e7a/28.06.2012_2012_25.pdf?MOD=AJPERES&CACHEID=42513bda-6eaa-4a3f-a257-239149e51e7a.
- Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1982.
- Steinmo, Sven. "Historical Institutionalism." In *Approaches in the Social Sciences*, edited by Donatella Della Porta, and Michael Keating, 113-138. Cambridge: Cambridge University Press, 2008.
- Stephens, John D. *The Transition From Capitalism to Socialism*. Wiesbaden: Springer, 1979.
- Subaşat, Turan. "The Political Economy of Turkey's Economic Miracle." *Journal of Balkan and Near Eastern Studies* 16, no. 2 (2014): 137-160.
- Sulku, S. Nur, and D. Minbay Bernard. "Financial Burden of Healthcare Expenditures: Turkey." *Iranian Journal of Public Health* 41, no. 3 (2012): 48-64.
- Sunar, İlkay. "Populism and Patronage: The Demokrat Party and Its Legacy in Turkey." *Il Politico* 55, no. 4 (1990): 745-757.

- Sunar, İlkay. "The Politics of State Interventionism in 'Populist' Egypt and Turkey." In *Developmentalism and Beyond: Society and Politics in Egypt and Turkey*, edited by Ayşe Öncü, Çağlar Keyder, and Saad Eddin Ibrahim, 94-111. Cairo: AUC Press, 1994.
- Sunar, İlkay. *State, Society and Democracy in Turkey*. Istanbul: Bahçeşehir University, 2004.
- Tatar, Mehtap, Hacer Özgen, Bayram Şahin, Paolo Belli, and Peter Berman. "Informal Payments in the Health Sector: A Case Study from Turkey." *Health Affairs* 26, no. 4 (2007): 1029-1039.
- Tatar, Mehtap, Salih Mollahaliloğlu, Bayram Şahin, Sabahattin Aydın, Anna Maresso, and Cristina Hernández-Quevedo. "Turkey: Health System Review." *Health Systems in Transition* 13, no. 6, European Observatory on Health Systems and Policies, 2011.
- Terris, Milton. "The Three World Systems of Medical Care: Trends and Prospects." *American Journal of Public Health* 68, no. 11 (1978): 1125-1131.
- Terzioğlu, Ayşecan. "Healthcare for All? Rethinking Globalization and Health Inequalities in the Turkish Context." In *The Making of Neoliberal Turkey*, edited by Cenk Özbay, Maral Erol, Ayşecan Terzioğlu, and Z. Umut Turem. Farnham, Burlington: Ashgate Publishing, 2016.
- Titmuss, Richard M. "The Social Division of Welfare: Some Reflections on the Search for Equity." In *Essays on 'The Welfare State'* by Richard M. Titmuss, 34-55. Crows Nest: Allen & Unwin, 1958.
- Tokat, Mehmet. *Türkiye'de Sağlık Sektörünün Finansmanı*. Ankara: T.C. Sağlık Bakanlığı Sağlık Projesi Genel Koordinatörlüğü, 1993.
- Tokat, Mehmet. *Türkiye Sağlık Harcamaları ve Finansmanı 1992-1996*. Ankara: T.C. Sağlık Bakanlığı Sağlık Projesi Genel Koordinatörlüğü, 1998.
- Truman, David B. *The Governmental Process: Political Interests and Public Opinion*. Berkeley: University of California Press, 1951.
- Tuğal, Cihan. *Passive Revolution: Absorbing the Islamic Challenge to Capitalism*. Palo Alto: Stanford University Press, 2009.
- Tuğal, Cihan. *The Fall of the Turkish Model: How the Arab Uprisings Brought Down Islamic Liberalism*. New York: Verso Books, 2016.
- Tuohy, Carolyn Hughes. "Agency, Contract, and Governance: Shifting Shapes of Accountability in the Healthcare Arena." *Journal of Health Politics, Policy and Law* 28, no. 2-3 (2003): 195-216.
- Turan, İlter. "Unstable Stability: Turkish Politics at the Crossroads?" *International Affairs* 83, no. 2 (2007): 319-338.
- Turkish Statistical Institute. *Statistical Indicators 1923-2008*. Ankara, 2009.
- Türkiye Sigorta Birliği. *2013. Faaliyet Raporu*. Istanbul, 2014. Accessed August 14, 2016. <http://www.tsb.org.tr/Document/Publications/2013Annual%20Report.pdf>.

- Ulusoy, Kivanç. "Turkey's Fight Against Corruption: A Critical Assessment." *Global Turkey in Europe*, Commentary 19, November 2014. Accessed on August 14, 2016. http://www.iai.it/sites/default/files/gte_c_19.pdf.
- United Nations Development Group. *Turkey: Common Country Assessment*. Ankara, 2000.
- U.S. Congress. *Hospital Financing in Seven Countries*. Washington D.C.: U.S. Government Printing Office, May 1995. Accessed August 14, 2016. <http://ota.fas.org/reports/9525.pdf>.
- von Reibnitz, Christine, and Oda Hagemeyer. *Homecare. Ein Versorgungskonzept der Zukunft, Gesundheitswesen in der Praxis*. Heidelberg: Economica, 2005.
- Wall, Ann L. *Healthcare Systems in Liberal Democracies*. Hove: Psychology Press, 1996.
- Weber, Max. *Die "Objektivität" sozialwissenschaftlicher und sozialpolitischer Erkenntnis*. Schutterwald: Fischer, 1995.
- Wendt, Claus. "Der Gesundheitssystemvergleich: Konzepte und Perspektiven." Arbeitspapier 88, Mannheimer Zentrum für Europäische Sozialforschung, 2005. Accessed on August 14, 2016. http://edoc.vifapol.de/opus/volltexte/2014/5181/pdf/wp_88.pdf.
- Wendt, Claus. "Gesundheitssysteme im internationalen Vergleich." *Das Gesundheitswesen* 68, no. 10 (2006): 593-599.
- Wendt, Claus. *Krankenversicherung oder Gesundheitsversorgung? Gesundheitssysteme im Vergleich*. Wiesbaden: VS Verlag für Sozialwissenschaften, 2009.
- Wendt, Claus. "Mapping European Healthcare Systems: A Comparative Analysis of Financing, Service Provision and Access to Healthcare." *Journal of European Social Policy* 19, no. 5 (2009): 432-445.
- Wendt, Claus, Tuba Ağartan, and Monika-Ewa Kaminska. "Social Health Insurance Without Corporate Actors: Patterns of Self-Regulation in Germany, Poland and Turkey." *Social Science and Medicine* 86 (2013): 88-95.
- Wendt, Claus, Lorraine Frisina, and Heinz Rothgang. "Healthcare System Types: A Conceptual Framework for Comparison." *Social Policy & Administration* 43, no. 1 (2009): 70-90.
- Wendt, Claus, and Jürgen Kohl. "Translating Monetary Inputs Into Healthcare Provision: A Comparative Analysis of the Impact of Different Modes of Public Policy." *Journal of Comparative Policy Analysis* 12, no. 1-2 (2010): 11-31.
- Wendt, Claus, Simone Grimmeisen, and Heinz Rothgang. "Convergence or Divergence in OECD Healthcare Systems." In *International Cooperation in Social Security. How to Cope With Globalisation*, edited by Bea Cantillon, and Ivo Marx, 15-45. Mottel: Intersentia, 2005.
- White, Jenny. *Muslim Nationalism and the New Turks*. Princeton: Princeton University Press, 2014.
- Wilensky, Harold L. *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditure*. Berkeley: University of California Press, 1975.

- Wilensky, Harold L. *Rich Democracies: Political Economy, Public Policy, and Performance*. Berkeley: University of California Press, 2002.
- Willert, Michaela. "Private Altersvorsorge in Deutschland und Großbritannien. Ein Vergleich der sozialen Regulierung und ihrer Wirkung." Doctoral Dissertation. Free University Berlin. 2011.
- World Bank. *Turkey. Reforming the Health Sector for Improved Access and Efficiency. Volume 1: Main Report*. Washington, D.C.: Human Development Sector Unit Europe and Central Asia Region, 2003. (2003a).
- World Bank. *Turkey. Reforming the Health Sector for Improved Access and Efficiency. Volume 2: Background Papers*. Washington, D.C.: Human Development Sector Unit Europe and Central Asia Region, 2003. (2003b).
- World Bank. *Turkey. Poverty and Coping After Crises. Volume I: Main Report*. Washington D.C.: Human Development Unit Europe and Central Asia Region, 2003. (2003c).
- World Bank. *Turkey. Performance-Based Contracting Scheme in Family Medicine – Design and Achievements*. Washington: Human Development Sector Unit Europe and Central Asia Region, 2013.
- World Bank and State Institute of Statistics Turkey. *Turkey Joint Poverty Assessment Report. Volume I: Main Report*. Ankara, 2005.
- Xu, Ke, David B. Evans, Kei Kawabata, Riadh Zeramdini, Jan Klavus, and Christopher Murray. "Household Catastrophic Health Expenditure: A Multicountry Analysis." *The Lancet* 362, no. 9378 (2003): 111-117.
- Yardım, Mahmut Saadi, Nesrin Çilingiroğlu, and Nazan Yardım. "Catastrophic Health Expenditure and Impoverishment in Turkey." *Health Policy* 94, no. 1 (2010): 26-33.
- Yardım, Mahmut S., Nesrin Çilingiroğlu, and Nazan Yardım. "Financial Protection in Health in Turkey: The Effects of the Health Transformation Programme." *Health Policy and Planning* 29, no. 2 (2014): 177-192.
- Yarman, Arsen. *Osmanlı Sağlık Hizmetlerinde Ermeniler ve Surp Pırığıç Ermeni Hastanesi Tarihi*. Istanbul: Ermeni Hastanesi Vakfı, 2001.
- Yaşar, Gülbiye Y., and Ece Uğurluoğlu. "Can Turkey's General Health Insurance System Achieve Universal Coverage?." *The International Journal of Health Planning and Management* 26, no. 3 (2011): 282-295.
- Yavuz, M. Hakan. *Islamic Political Identity in Turkey*. Oxford: Oxford University Press, 2003.
- Yavuz, M. Hakan, ed. *The Emergence of a New Turkey: Democracy and the AK Parti*. Salt Lake City: University of Utah Press, 2006.
- Yazıcı, Berna. "The Return to the Family: Welfare, State, and Politics of the Family in Turkey." *Anthropological Quarterly* 85, no. 1 (2012): 103-140.

- Yılmaz, Volkan. "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income." *New Perspectives on Turkey* 48 (2013): 55-77.
- Yılmaz, Volkan. "Health Reform and New Politics of Healthcare in Turkey." PhD Dissertation. University of Leeds, 2014.
- Yoltar, Çağrı. "When the Poor Need Healthcare: Ethnography of State and Citizenship in Turkey." *Middle Eastern Studies* 45, no. 5 (2009): 769-782.
- Yükseköğretim Kurulu. *Türkiye'de Sağlık Eğitimi ve Sağlık İnsangücü Durum Raporu*. Eskişehir, 2014.
- Zencir, M., N. Kuzu, N. Gördeles Beşer, A. Ergin, B. Çatak, and T. Şahiner. "Cost of Alzheimer's Disease in a Developing Country Setting." *International Journal of Geriatric Psychiatry* 20, no. 7 (2005): 616-622.
- Zürcher, Erik Jan. *Turkey: A Modern History*. New York: I.B. Tauris, 2004.
- Zürn, Michael. *The State in the Post-National Constellation: Societal Denationalization and Multi-Level Governance*. Würzburg: Arena, 1999.

Laws and regulations

- Köy Kanunu. No. 442. Resmi Gazete. 7 April 1924. (*Village Law*).
- Borçlar Kanunu. No. 818. Resmi Gazete. 22 April 1926. (*Law of Obligations*).
- Umumî Hıfzıssıhha Kanunu. No. 1489. Resmi Gazete. 6 May 1930 (*Public Health Law*).
- Askeri ve Mülki Tekaüt Kanunu. No. 1517. Resmi Gazete. 11 June 1930. (*Military and Civil Retirement Law*).
- Hususi Hastaneler Kanunu. No. 2219. Resmi Gazete. 5 June 1933. (*Private Hospitals Law*).
- Zührevî Hastalıklar ve Fuhuşla Mücadele Nizamnamesi. No. 2703. Resmi Gazete. 3 March 1934. (*Law for Combating Venereal Diseases and Prostitution*).
- İş Kanunu. No. 837. Resmi Gazete. 8 June 1936. (*Labor Law*).
- İşçi Sigortaları Kurumu Kanunu. No. 4792. Resmi Gazete. 16 July 1945. (*Labor Insurance Institution Law*).
- İş Kazaları, Meslek Hastalıkları ve Analık Sigortaları Kanunu. No. 4772. Resmi Gazete. 27 June 1945 (*Work Accidents, Occupational Diseases, and Maternity Insurances Law*).
- İhtiyarlık Sigortası Kanunu. No. 5417. Resmi Gazete. 2 June 1949 (*Old Age Insurance Law*).
- Türkiye Cumhuriyeti Emekli Sandığı Kanunu. No. 5434. Resmi Gazete. 8 June 1949. (*Law on the Retirement Fund of the Turkish Republic*).

Eczacılar ve Eczaneler Hakkında Kanun. No. 6197. Resmi Gazete. 18 December 1953. (*Law on Pharmacists and Pharmacies*).

Hastaneler Talimatnamesi. No. 4502. Resmi Gazete. 4 April 1955. (*Regulations on Hospitals*).

Sigorta Murakabe Kanunu. No. 7397. Resmi Gazete. 30 December 1959. (*Law on Insurance Regulation*).

Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun. No. 224. Resmi Gazete. 12 January 1961. (*Socialization of Health Services Law*).

Sosyal Sigortalar Kanunu. No. 506. Resmi Gazete. 17 July 1964. (*Social Insurance Law*).

Devlet Memurları Yasası. No. 657. Resmi Gazete. 14 July 1965. (*Civil Servants Law*).

Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu Kanunu. No. 1479. Resmi Gazete, 14 September 1971. (*Law on the Social Insurance Institution for Tradesmen and Craftsmen and Other Self-Employed Workers*).

Yataklı Tedavi Kurumları İşletme Yönetmeliği. No. 7387. Resmi Gazete. 26 November 1973. (*Regulation on the Administration of Inpatient Care Institutions*).

Bakanlar Kurulu Kararı. No. 17820. Resmi Gazete. 22 September 1982. (*Decree of the Council of Ministers*).

Özel Hastaneler Tüzüğü. No. 17924. Resmi Gazete. 10 January 1983. (*Private Hospitals Charter*).

Tarım İşçileri Sosyal Sigortalar Kanunu. No. 2925. Resmi Gazete. 17 October 1983. (*Agricultural Workers Social Insurance Law*).

Huzurevleri Yönetmeliği. Resmi Gazete. 24 November 1984. (*Regulation on Retirement Centers*).

Bağ-Kur Sağlık Sigortası Yardımları Yönetmeliği. 1 September 1986. (*Regulation on Bağ-Kur Health Insurance Assistance*).

Eğitim, Gençlik, Spor ve Sağlık Hizmetleri Vergisinin İhdası. No. 3074. Resmi Gazete. 24 March 1988. (*Education, Youth, Sports, and Health Taxes Law*).

Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşlanması Hakkında Kanun. No. 3816. Resmi Gazete. 3 July 1992. (*Law Concerning State Coverage of Treatment Expenses of Citizens Who Lack the Ability to Pay by Issuing a Green Card*).

Özel Hastaneler Yönetmeliği. No. 24708. Resmi Gazete Tarihi. 27 March 2002. (*Regulation on Private Hospitals*).

Aile Hekimliği Kanunu. No. 5258. Resmi Gazete. 24 November 2004. (*Family Medicine Law*).

Evde Bakım Hizmetleri Sunumu Hakkında Yönetmelik. Resmi Gazete Tarihi. 10. March 2005. (*Regulation Concerning the Provision of Home Care Services*).

Sosyal Güvenlik Kurumu Kanunu. No. 5502. Resmi Gazete. 20 May 2006. (*Social Security Institution Law*).

Sosyal Güvenlik ve Genel Sağlık Sigortası Kanunu. No. 5510. Resmi Gazete. 16 June 2006. (*Social Security and General Health Insurance Law*).

Bakıma Muhtaç Özürlülerin Tesbiti Ve Bakım Hizmeti Esaslarının Belirlenmesine İlişkin Yönetmelik. Resmi Gazete. 30 July 2006. (*Regulation Concerning the Identification of Disabled in Need of Care and Determining the Guidelines for Care Services*).

Sigortacılık Kanunu. No. 5684. Resmi Gazete. 3 June 2007. (*Insurance Law*).

Doktorluk, Hemşirelik, Ebelik, Diş Hekimliği, Veterinerlik, Eczacılık ve Mimarlık Eğitim Programlarının Asgari Eğitim Koşullarının Belirlenmesine Dair Yönetmelik. Resmi Gazete. 2 February 2008. (*Regulation Concerning the Specification of Minimum Requirements for Medicine, Nursing, Midwifery, Dentistry, Veterinary Medicine, Pharmaceuticals, and Architecture Training Programs*).

Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına Dair Kanun. No. 5947. Resmi Gazete. 21 January 2010. (*Law Regarding Full-Time Employment of University and Health Personnel*).

Genel Sağlık Sigortası Kapsamında Gelir Tespiti, Tescil ve İzleme Sürecine İlişkin Usul ve Esaslar Hakkında Yönetmelik. No. 2011/2512. Resmi Gazete. 28 December 2011. (*Regulation Regarding the Procedures and Principles Related to Revenue Assessment, Registration and Monitoring Processes within the Scope of General Health Insurance*).

Aile Hekimliği Uygulama Yönetmeliği. Resmi Gazete Sayısı. 25 January 2013. (*Regulation on the Implementation of Family Medicine*).

Yabancılar ve Uluslararası Koruma Kanunu. No. 6458. Resmi Gazete. 4 April 2013. (*Law on Foreigners and International Protection*).

Özel Sağlık Sigortaları Yönetmeliği. Resmi Gazete. 23 October 2013. (*Regulation on Private Health Insurance*).

Geçici Koruma Yönetmeliği. No. 8027. Resmi Gazete. 13 August 2014. (*Temporary Protection Regulation*).

Sağlık Bakanlığı ve Bağlı Kuruluşları Tarafından Evde Sağlık Hizmetlerinin Sunulmasına Dair Yönetmelik. Resmi Gazete. 27 February 2015. (*Regulation on the Provision of Home Care by the Ministry of Health and Affiliated Institutions*).

Online databases

Database for Institutional Comparisons in Europe (DICE). Accessed August 14, 2016. <http://www.cesifo-group.de/ifoHome/facts/DICE.html>.

Organisation for Economic Co-operation and Development Health Statistics 2016. Accessed August 14, 2016. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

Sosyal Güvenlik Kurumu online statistics. Accessed August 14, 2016.

<http://www.sgk.gov.tr/wps/portal/sgk/tr/kurumsal/istatistik>.

Turkish Statistical Institute online statistics. Accessed August 14, 2016.

<http://www.turkstat.gov.tr/Start.do>.

United Nations Economic Commission for Europe Statistical Database 2016. Accessed August 14, 2016.

http://w3.unece.org/PXWeb2015/pxweb/en/STAT/STAT__30-GE__02-

[Families_households/052_en_GEFHAge1stMarige_r.px/?rxid=6962d26c-37a1-402d-beb2-42121f8accf0](http://w3.unece.org/PXWeb2015/pxweb/en/STAT/STAT__30-GE__02-Families_households/052_en_GEFHAge1stMarige_r.px/?rxid=6962d26c-37a1-402d-beb2-42121f8accf0).

World Health Organization online statistics. Accessed August 14, 2016. <http://www.who.int/gho/en/>.

Appendix I: Summary of findings

In this thesis, I examine the institutional transformation of the Turkish welfare state. More specifically, I analyze how healthcare policies and the healthcare system, defined as the actor constellation that finances, provides, and regulates healthcare, have changed under the Justice and Development Party (*Adalet ve Kalkınma Partisi*, AKP) government.

I contribute to the literature on the role of actors and institutions in healthcare policy and politics by exploring how the interdependency of various institutions and political ideas manifest in changing medical care arrangements in Turkey. Therefore, I make a theoretical and empirical contribution to two relatively unexplored fields of social science: first, Turkish social policy and second, the relationship between healthcare systems and welfare states.

Background

Since the 1980s, Turkey has undergone substantial social, economic, and political transformations. The most recent of these are the direct result of the political reforms of the AKP government. A prime example is the reforms that led to the transformation of the Turkish healthcare system. Prior to these reforms, Turkey's healthcare system was indicative of the country's underdeveloped welfare state. A large percentage of the population was excluded from public health insurance. Levels of inequality in access to services across different occupational and social groups were high. Furthermore, a general reluctance by the state to engage in welfare provision meant that many Turks relied on their family's means and readiness to finance and provide healthcare.

Since the AKP came to power in 2002, government healthcare coverage has reached universal levels and the newly established Social Security Institution (*Sosyal Güvenlik Kurumu*, SGK) ensures equal rights and benefits for all insureds. At the same time, healthcare provision was reorganized, leading to better access and higher quality services. However, a number of studies have argued that the AKP reforms simply form part of a larger neo-liberal project, and are, therefore, purely symptomatic of the economic and political transformation of the country. They point to the dramatic increase in the number of for-profit healthcare providers and fear the emergence of a two-tier healthcare system, in which the state provides universal access to rudimentary care, while wealthier segments of society opt for market-owned, high-quality providers financed by voluntary health insurance schemes.

These developments raise a number of research questions on the nature and scope of recent changes in healthcare policy and politics: What has changed in healthcare policy since the AKP came to power? How profound are these changes? How do they affect the actor constellation of the Turkish healthcare system? Do policy changes imply a new role of the state in healthcare and welfare provision? Has a new type of modern healthcare system emerged in Turkey different from its counterparts in Europe?

How do changes in healthcare policy and politics under the AKP relate to the general transformation of political institutions in Turkey?

Analytical framework and main hypothesis

In order to answer these questions, I present an analytical framework, which elaborates on theoretical and methodological approaches that bridge the gap between welfare state and healthcare system analysis. This framework demonstrates that in the realm of healthcare, legal and organizational features of the state, the market, non-governmental actors, and the family are systematically interwoven. At the same time, it conceptualizes changes in healthcare policy and the actor constellation of the Turkish healthcare system.

This thesis is, in particular, guided by two theoretical approaches: the historical institutionalist approach and the regime approach. The historical institutionalist approach offers a comprehensive framework for the analysis of institutional changes under the AKP government by putting them into context with the long-term transformation of healthcare institutions in Turkey. It explains why established healthcare institutions change at a certain point in time and conceptualizes linkages between the AKP healthcare reforms and the broader political and socio-economic context.

The regime approach, complemented by the findings of governance and feminist approaches, offers a comprehensive theoretical and methodological framework for the analysis of the transformation of healthcare policy and the actor constellation that constitutes the Turkish healthcare system. It stresses changes in the institutional links between the state, the market, non-governmental actors, and the family in the realm of healthcare, as well as the ideological underpinnings of these institutional arrangements.

In order to conceptualize changes in the role of political actors and institutions in healthcare policy, I elaborate on two existing frameworks: First, the typology developed by Claus Wendt et al., which highlights cross-national variations as well as internal changes in the role of actors and modes of governance within different healthcare systems and second, Peter Hall's conceptualization of policy change.¹²³ Methodologically, my thesis is based on the qualitative analysis of key legislation; expert interviews; the secondary analysis of statistical healthcare data from various sources; as well as secondary literature analysis.

Based on this framework, I present the following main hypothesis: The political hegemony of the AKP government constitutes a critical juncture, which has led to a paradigm shift in healthcare policy and a

¹²³ Wendt, Claus, Lorraine Frisina, and Heinz Rothgang. "Healthcare System Types: A Conceptual Framework for Comparison." *Social Policy & Administration* 43, no. 1 (2009): 70-90; Hall, Peter A. "Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain." *Comparative Politics* 25, no. 3 (1993): 275-296.

system change in the actor constellation that constitutes the healthcare system of contemporary Turkey.

Findings

The key findings of my dissertation can be summarized as follows: First, under AKP governance a mature welfare state has emerged that protects its citizens from health-related risks on the basis of social rights. I argue that the rise of the AKP marks a critical juncture that has led to a paradigm shift in healthcare policy. Prior to the AKP reforms, a patchwork of fragmented healthcare financing schemes and the exclusion of a significant share of the population from healthcare, characterized a system devoid of any consistent policies. This picture has now changed as a direct result of the AKP reforms in healthcare financing and provision, which have created a new policy paradigm of a healthcare system based on universal coverage.

Accordingly, my findings evaluate the claim that the AKP has commodified healthcare services. I show that income levels were, in fact, already a major cause of healthcare inequalities prior to the AKP reforms. Access to inpatient care for a third of the population was entirely contingent on their market position. Furthermore, high levels of service commodification were upheld by state policies, which facilitated the common practice among healthcare providers of charging patients copayments. The AKP policies have led to a significant reduction in these out-of-pocket payments. While I find that for-profit providers have gained importance, my research also shows that recent market momentum has been limited to the hospital sector and that outpatient curative care has, in fact, been decommodified. The state has significantly increased its control over market actors and has placed statutory caps on fees-for-services in for-profit hospitals and has restricted state-employed physicians from earning ancillary incomes in the private sector. This suggests that policymakers have subordinated the privatization of medical care to the new policy paradigm of establishing universal coverage.

My second key finding is that a system change in the Turkish healthcare system, defined as shifts in the predominant actors in healthcare financing, provision, and regulation, did not occur. Moreover, the AKP reforms have not challenged the predominant perception of statehood that has underpinned the Turkish healthcare system since the late Ottoman Empire. Healthcare governance has been dominated by the state, which intervenes in society and the economy in a hierarchical manner. This becomes most apparent when considering the institutional structure of the SGK. As with previous decades, the state still controls the non-governmental SGK by appointing a significant share of the members of its executive organs. This institutional characteristic sets Turkey apart from the healthcare systems of corporatist welfare states, in which the state's role is limited to setting the legal framework that allows highly autonomous interest groups and social insurance agencies to negotiate modes of coverage and systems of finance. In contrast, these decisions have been made by the state in Turkey since the

inception of the social insurance system. Accordingly, the AKP reforms have been path-dependent with regard to the mode of governance.

Third, my research highlights another specific trait of the Turkish healthcare system: the importance of the family. I show that prior to AKP rule, a number of policies existed that were underpinned by the principle that the family is ultimately responsible for the healthcare of its members, both in terms of financing and provision. However, the state did little to support this presumed role. In contrast, the AKP has lessened some of the burden on families through a series of measures: stricter regulation of providers; improved access to better services; a significant reduction in out-of-pocket payments; and establishing a network of state-owned home care providers.

At the same time, my research has revealed that state policies under the AKP aim at a formalization and institutionalization of the family's role. In healthcare financing, the establishment of the comprehensive social health insurance scheme has shifted the risk pooling for many unemployed women from the social health insurance schemes to the household. Furthermore, in some healthcare financing schemes, cohabitation is a key entitlement criterion and the state also imposes for-profit hospital sector reform costs on the family by allowing providers to charge high copayments for hotel costs. Accordingly, I have shown how there has been a shift from inpatient to home-based long-term care in healthcare provision. Moreover, the state gives financial incentives to families who provide home care and allows state-owned hospitals to integrate family members into medical care provision by giving them the status of *refakatçi* (companion).

AKP reforms continue to be underpinned by the premise that the family is responsible for the healthcare of its members. While new policies aim at strengthening the family's capacity, they are based on a highly gendered nature of healthcare provision. Universal coverage and improvements in the quality and quantity of providers have effectively decommodified healthcare by making an individual's access to healthcare less dependent on his or her market position. However, similar to mature western and northern European welfare states, the prerequisite for this decommodification is unpaid care work carried out by women in the home. Based on these findings I conclude that the healthcare policy reforms of the AKP reproduce existing gender roles and that the establishment of universal coverage has had significantly gendered effects at the expense of female autonomy.

Appendix II: Kurzfassung der Ergebnisse

In dieser Dissertation untersuche ich den institutionellen Wandel des türkischen Wohlfahrtsstaates. Konkreter Forschungsgegenstand ist die Entwicklung der Gesundheitspolitik und des Gesundheitssystems unter der Regierung der Partei für Gerechtigkeit und Entwicklung (*Adalet ve Kalkınma Partisi*, AKP). Meine Analyse ist Teil der wissenschaftlichen Debatte um die Rolle von Akteuren und Institutionen in der Gestaltung von Gesundheitspolitik. Anhand des türkischen Beispiels zeige ich, wie die Verknüpfung von Institutionen und politischen Ideen in wandelnden Arrangements medizinischer Versorgung Ausdruck findet. Mit meiner Dissertation leiste ich einen Beitrag zu zwei relativ unbearbeiteten sozialwissenschaftlichen Feldern: Der türkischen Sozialpolitik und der Verknüpfung von Gesundheitssystemen und Wohlfahrtsstaaten.

Forschungsanstoß

Bereits seit Beginn der 1980er Jahre hat die Türkei eine Reihe tiefgreifender sozio-ökonomischer und politischer Wandlungsprozesse durchlaufen. Nach ihrem Amtsantritt im Jahr 2002 wurde diese Transformation maßgeblich durch die Reformen der AKP-Regierung geprägt. Eines der wichtigsten Beispiele für diese Wandlungsprozesse ist der Umbau des türkischen Gesundheitssystems.

Die medizinische Versorgung stand zuvor exemplarisch für die Unterentwicklung des türkischen Wohlfahrtsstaates. Ein Drittel der Bevölkerung war nicht krankenversichert und die Qualität medizinischer Leistungen war abhängig vom beruflichen und sozialen Status des Patienten. Die allgemeine Zurückhaltung des Staates in der Wohlfahrtsversorgung stärkte die Abhängigkeit des Einzelnen von der Familie und ihrer Bereitschaft und Fähigkeit, im Krankheitsfall medizinische Leistungen zu finanzieren und zu erbringen.

Seit Amtsantritt der AKP hat sich dieses Bild geändert. Das öffentliche Gesundheitssystem deckt heute die gesamte Bevölkerung ab, die neu gegründete Anstalt für Soziale Sicherheit (*Sosyal Güvenlik Kurumu*, SGK) gewährt allen Versicherten gleiche Rechte und Leistungen und die Qualität der medizinischen Versorgung wurde maßgeblich verbessert.

Trotz dieser Entwicklungen argumentieren eine Reihe von Studien, dass die Gesundheitsreformen der AKP Teil eines neo-liberalen Projektes und somit paradigmatisch für die generelle wirtschaftliche und politische Umwälzung der türkischen Gesellschaft sind. Hervorgehoben wird in diesem Zusammenhang die steigende Relevanz wirtschaftlich ausgerichteter Krankenhäuser verbunden mit der Warnung vor einem Zwei-Klassen Gesundheitssystem, in dem der Staat die rudimentäre Grundversorgung einkommensschwacher Bevölkerungsschichten gewährleistet, während privatversicherte Besserverdienende qualitativ hochwertigere Leistungen privater Versorger in Anspruch nehmen.

Diese Entwicklungen werfen eine Reihe, die Art und das Ausmaß des gesundheitspolitischen Wandels betreffende, Forschungsfragen auf: Was hat sich seit Amtsantritt der AKP in der türkischen Gesundheitspolitik geändert? Wie sehr hat sich die Gesundheitspolitik gewandelt? Wie wirkten sich diese Wandlungsprozesse auf die Akteurskonstellation des türkischen Gesundheitssystems aus? Führen die Reformen zu einer Neudefinition der Rolle des Staates in der Gesundheitsversorgung und dem türkischen Wohlfahrtsstaat? Ist ein neues Gesundheitssystem entstanden, das sich von den Systemen entwickelter Wohlfahrtsstaaten in Europa unterscheidet? Wie verortet sich der gesundheitspolitische Wandel in den übergreifenden politischen und gesellschaftlichen Transformationsprozessen in der Türkei?

Analyserahmen und Kernhypothese

Der meiner Untersuchung zugrundeliegende Analyserahmen baut auf den theoretischen und methodischen Ansätzen auf, die eine Brücke zwischen der vergleichenden Gesundheitssystemforschung und Wohlfahrtsstaatsforschung schlagen. Dieser Analyserahmen fußt auf der Annahme, dass die Institutionen von Staat, Markt, nicht-staatlichen Akteuren und der Familie in der Gesundheitsversorgung systemisch verflochten sind. Gleichzeitig konzeptualisiert er gesundheitspolitischen Wandel und die Transformation von Gesundheitssystemen.

Meine Untersuchung wird durch zwei theoretische Ansätze angeleitet: Den historischen Institutionalismus und den Regimeansatz. Der historische Institutionalismus erklärt institutionellen Wandel unter der AKP-Regierung und verortet diesen in der historischen Entwicklung politischer und medizinischer Institutionen. Er bietet einen Deutungsansatz für die Frage warum etablierte Institutionen zu einem bestimmten historischen Zeitpunkt einen Wandlungsprozess unterlaufen und konzeptualisiert die Verknüpfung der gesundheitspolitischen Reformen der AKP-Regierung mit der politischen und sozio-ökonomischen Transformation der Türkei.

Der Regimeansatz, ergänzt durch Erkenntnisse der feministischen Wohlfahrtsstaatsforschung und der Governance-Forschung, bietet einen umfassenden theoretischen und methodischen Rahmen für die Untersuchung des gesundheitspolitischen Wandels und der Transformation der Akteurskonstellation des türkischen Gesundheitssystems. Der Ansatz wirft ein Schlaglicht auf die institutionelle Verknüpfung von Staat, Markt, nicht-staatlichen Akteuren und der Familie in der Gesundheitsversorgung und hebt die diesen Institutionen zugrundeliegenden politischen Ideen hervor. Um Wandel in der Rolle gesundheitspolitischer Akteure und Institutionen zu konzeptualisieren, integriere ich zwei bestehende Analyserahmen in meine Arbeit: Erstens, die von Wendt et al. entwickelte Typologie, die sowohl den internationalen Vergleich von Gesundheitssystemen als auch die Untersuchung von Wandel in der systeminhärenten Rolle von Akteuren und der Art der politischen

Steuerung ermöglicht.¹²⁴ Zweitens, das von Peter Hall entwickelte Konzept zur Messung von politischem Wandel.¹²⁵ Methodisch stützt sich meine Untersuchung auf die Analyse von Gesetzen und anderen Rechtsdokumenten, Experteninterviews, die Sekundäranalyse von quantitativen und qualitativen Daten über Gesundheitssystemen und die Analyse der bestehenden Sekundärliteratur. Aufbauend auf diesem Analyserahmen teste ich die folgende Kernhypothese: Die politische Hegemonie der AKP-Regierung konstituierte eine kritische Phase (*critical juncture*), in der ein gesundheitspolitischer Paradigmenwechsel und ein Systemwandel in der Akteurskonstellation des Gesundheitssystems stattfand.

Forschungsergebnisse

Die wichtigsten Ergebnisse meiner Dissertation können wie folgt zusammengefasst werden: Erstens, die Reformen der AKP-Regierung führten zur Herausbildung eines Wohlfahrtsstaates, der seine Bürger auf der Grundlage sozialer Rechte vor mit Krankheit verbundenen sozialen Risiken schützt. Die Machtübernahme der AKP läutete eine kritische Phase (*critical juncture*) ein, die einen gesundheitspolitischen Paradigmenwechsel ermöglichte. Vor Amtsantritt der AKP-Regierung war keine einheitliche Gesundheitspolitik erkennbar und das Gesundheitssystem zeichnete ein hohes Maß an Fragmentierung, Ungleichheit und die Ausgrenzung weiter Teile der Bevölkerung aus. Die umfassende Reform der Gesundheitsfinanzierung und der medizinischen Versorgung unter der AKP-Regierung folgten dem neuen Paradigma, eine flächendeckende Gesundheitsversorgung der Bevölkerung zu gewährleisten.

Meine Forschungsergebnisse stellen die Annahme in Frage, dass die Reformen der AKP zu einer Kommodifizierung von Gesundheitsleistungen geführt haben. Vielmehr zeige ich, dass bereits vor Amtsantritt der AKP Zugang zum Gesundheitssystem und die Qualität der Versorgung maßgeblich von der wirtschaftlichen Situation des Patienten abhängig war. Dies galt insbesondere für das nicht krankenversicherte Drittel der Bevölkerung. Das hohe Maß der Kommodifizierung von Gesundheitsleistungen war auch Resultat der staatlichen Gesundheitspolitik und der fehlenden Regulierung privater Zuzahlungen von Patienten für Gesundheitsleistungen.

Die Reformen der AKP-Regierung haben das Niveau privater Zuzahlungen maßgeblich gesenkt. Im Krankenhaussektor haben wirtschaftlich handelnde Akteure zwar an Bedeutung gewonnen, in der Primärversorgung zeigt meine Untersuchung dagegen eine deutliche Dekommodifizierung von Gesundheitsleistungen. Des Weiteren hat sich das Maß staatlicher Regulierung wirtschaftlich ausgerichteter Akteure im Gesundheitswesen deutlich erhöht. Höchstgrenzen für Behandlungskosten

¹²⁴ Wendt, Claus, Lorraine Frisina, and Heinz Rothgang. "Healthcare System Types: A Conceptual Framework for Comparison." *Social Policy & Administration* 43, no. 1 (2009): 70-90.

¹²⁵ Hall, Peter A. "Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain." *Comparative Politics* 25, no. 3 (1993): 275-296.

in privaten Krankenhäusern wurden eingeführt und in öffentlichen Einrichtungen praktizierende Ärzte dürfen nicht länger im privaten Sektor zusätzliche Einkommen erwirtschaften. Diese Reformen zeigen, dass politische Entscheider die Privatisierung der Gesundheitsversorgung dem Paradigma der flächendeckenden Gesundheitsversorgung unterordnen.

Die zweite wichtige Erkenntnis meiner Dissertation ist, dass ein Systemwechsel, definiert als ein Wandel der zentralen Akteure in der Finanzierung, Versorgung und Regulierung von Gesundheit, nicht stattgefunden hat. Des Weiteren hat sich das seit Ende des Osmanischen Reiches vorherrschende Verständnis von Staatlichkeit und die Art der politischen Steuerung nicht gewandelt. Die Governance des Gesundheitswesens zeichnet sich weiterhin durch hierarchische Steuerung durch staatliche Institutionen aus. Dieses Verständnis von Staatlichkeit wurde auch in der neu gegründeten SGK institutionalisiert. Die AKP-Regierung führt die Praxis ihrer Vorgänger fort und besetzt die Entscheidungsorgane der SGK zu einem wesentlichen Teil mit Regierungsvertretern. Durch diese institutionelle Besonderheit setzt sich das türkische Gesundheitssystem klar von den korporatistischen Wohlfahrtsstaaten Westeuropas ab. In Letzteren setzt der Staat lediglich den regulativen Rahmen, der es autonomen, nicht-staatlichen Akteuren erlaubt, die Parameter der Gesundheitsfinanzierung und medizinischen Versorgung auszuhandeln. In der Türkei trifft seit der Gründung des Sozialversicherungssystems der Staat diese Entscheidungen. Entsprechend sind die Reformen der AKP bezüglich der Art der politischen Steuerung pfadabhängig.

Das dritte zentrale Ergebnis meiner Untersuchung ist, dass die Familie eine herausragende Rolle im türkischen Gesundheitssystem spielt. Vor Amtsantritt der AKP-Regierung lag der Gesundheitspolitik die Annahme zu Grunde, dass der Familie eine zentrale Verantwortung in der Finanzierung und der Erbringung von Gesundheitsleistungen zukommt. Eine Stärkung der Kapazitäten der Familie und eine Befähigung diese Rolle einzunehmen seitens des Staates blieb jedoch aus.

Die Reformen der AKP-Regierung haben zu einer maßgeblichen Entlastung der Familie geführt. Der Zugang zu und Qualität der Gesundheitsversorgung wurde deutlich verbessert und Anbieter von Leistungen werden stärker reguliert. Private Zuzahlungen haben in der Gesundheitsfinanzierung an Bedeutung verloren und ein staatliches Netzwerk häuslicher Gesundheitsversorgung wurde aufgebaut. Gleichzeitig zeigt meine Untersuchung, dass die gesundheitspolitischen Reformen der AKP-Regierung zu einer Institutionalisierung und Formalisierung der Rolle der Familie im türkischen Gesundheitssystem führen. In der Gesundheitsfinanzierung verlagert die Einführung der Pflichtversicherung das Risiko-Pooling lediger, arbeitsloser Frauen von der SGK auf Privathaushalte. Haushaltszugehörigkeit bleibt ein zentrales Kriterium für die Anspruchsberechtigung und Beitragsbemessung einkommensschwacher Bürger und wirtschaftlich ausgerichtete Krankenhäuser können durch gesundheitspolitische Reformen entstandene Mehrkosten durch die Berechnung privater Zuzahlungen für Übernachtungskosten teilweise auf Haushalte abwälzen.

In der Gesundheitsversorgung zeigt meine Untersuchung eine Verlagerung von institutioneller zu häuslicher Langzeitpflege. Der Staat bietet zudem finanzielle Anreize für die häusliche Pflege durch Familienmitglieder. Des Weiteren binden Krankenhäuser Familienangehörige in die stationäre medizinische Betreuung ein, indem sie diesen den Sonderstatus als *refakatçı* (Begleiter) gewähren.

Die gesundheitspolitischen Reformen der AKP-Regierung bauen somit weiter auf der Annahme auf, dass die Familie für die Finanzierung und medizinische Versorgung ihrer Mitglieder zuständig ist. Während der Staat erstmals die Rolle der Familie stärkt, verstärken die gesundheitspolitischen Reformen der AKP geschlechterspezifische Ungleichheiten in der Gesundheitsversorgung. Die Einführung der flächendeckenden Gesundheitsversorgung hat medizinische Leistungen dekommodifiziert und den Zugang zum Gesundheitssystem von der wirtschaftlichen Situation des Patienten entkoppelt. Wie im Modernisierungsprozess der entwickelten, west- und nordeuropäischen Wohlfahrtsstaaten wird die Dekommodizierung sozialer Leistungen jedoch durch die unbezahlte Arbeit von Frauen ermöglicht. Aufbauend auf diesen Ergebnissen komme ich zu dem Schluss, dass die gesundheitspolitischen Reformen der AKP-Regierung bestehende Geschlechterverhältnisse reproduzieren und dass die Einführung der flächendeckenden Gesundheitsversorgung mit der Einschränkung der Autonomie von Frauen einhergeht.