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Putting the Neoliberal Transformation of Turkish Healthcare System and Its Problems into a Historical Perspective

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Abstract

The principal objective of this article is to analyze how the Health Transformation Program (HTP), the latest reform to have overhauled the Turkish healthcare system, has been designed according to the project of global neoliberal capital accumulation. This reform is in line with the transformation of the Turkish economy, which has been ongoing since the 1980s. With this aim in mind, this research examines how neoliberalism affects both the provision of healthcare services and household healthcare expenditures in Turkey. The article concludes that, as well as the HTP transferring public funds to the private sector and promoting the rent-seeking characteristic of the Turkish bourgeoisie, the financial burden of healthcare services on primarily the middle and lower-income groups in Turkey has increased dramatically and led to a rise in out-of-pocket expenditures.

JEL Classification: H51, I14

Keywords

healthcare reform, neoliberal transformation in healthcare, Turkish healthcare system, out-of-pocket expenditures, equity in healthcare

1. Introduction

The healthcare system in Turkey has undergone an across-the-board change since the initiation of the Health Transformation Program (HTP) in 2003. The Ministry of Health of the Republic of Turkey (MoH) defined the fundamental goal of this program as the provision of accessible, qualified, and sustainable healthcare services in an effective, productive, and just manner. However, this program has resulted in a transition from the funding of public healthcare services through

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the national budget and public insurance, to a neoliberal public insurance system which has increased people's out-of-pocket expenditures, as well as insurance charges, dramatically.

The transformation of the healthcare system has taken place in parallel with the transition to a neoliberal economy in Turkey. This transition has been driven by the neoliberal ideology associated with reducing the role of the state to three market-related functions: "Protecting and sustaining the functioning of markets; using whatever policy instruments are available to entice capital, both foreign and domestic, to come into or stay within the economy; and undertaking certain minimal expenditures inter alia to ameliorate the excesses perpetrated by the market, e.g., the so-called 'safety-net,' so as to make the regime socially viable" (Patnaik 1994: 683).

To accomplish the ideological ends of neoliberalism, international economic organizations such as the World Bank (WB), the International Monetary Fund (IMF), and the World Trade Organization (WTO) have urged governments to accept the structural adjustment programs which consist of: "(1) Fiscal reforms to 'generate savings,' that is, 'austerity'; (2) structural reforms to 'enhance competitiveness and growth,' such as privatization of public assets and deregulation of the markets including the labor market, that is, 'labor market flexibility'; and (3) financial reforms to 'enhance financial stability,' such as banking regulations, and bank recapitalization and resolution mechanisms" (Öncü 2015: 10–11).

The implementation of these reforms in Turkey, and the integration of international economic organizations into the policy-making process, necessitated getting rid of the import-substitution industrialization, which was identified as the root cause of macroeconomic instability, in order to open the way for international finance capital to become the new impetus for a developmental political economy in the country (Yalman 2019: 51). The subsequent transition from import-substitution to an export-oriented strategy in the early 1980s was coupled with the transition from an interventionist mode of regulation to a neoliberal regime. As Korkut Boratav notes, the most striking common characteristic of the Turkish bourgeoisie[1] in both phases was rent seeking (Yalman 2010: xiii).[2] The continuation of interventionism means "in the popular jargon of the neoliberal political economy, the domination of political rationality over economic rationality with adverse consequences for the growth prospects of the economy since it perpetuates incentive structures that generalize 'rent-seeking' behavior" (Yalman 2010: 8–9). As a result, according to neoliberal justifications, the state is seen as an impediment to economic growth (Thomas et al. 1991: 110–11; Yalman 2010: 9).[3] But, contrary to the neoliberal assumption, new patterns of rent seeking have flourished since the transition to neoliberalism in Turkey (Boratav 2016: 3). This point is a contradiction inherent to the theoretical underpinnings of the neoliberal policy agenda. Treating the state and economy as two externally related domains eclipses the role of state power in reproducing the market economy as a form of capitalist relations of production under neoliberalism.

In the 1970s, the understanding of the state as an instrument of society to initiate change and cure the ills of capitalist development was discredited by the perception of the market as

[1]In this study, the bourgeoise or the capitalist class is specifically referring to the historical class encompassing industrial, financial, commercial, and land-owning factions. Owning means of production and of exchange, the bourgeoise consists of individual capitalists, companies, corporations, as well as associations and organizations of business groups (Boratav 2016; Duménil, Löwy, and Renault 2009: 21; Merle 1999).

[2]The rent-seeking characteristic of the Turkish bourgeoisie would also prove to be a potent driving force toward the neoliberal transformation of the Turkish healthcare system.

[3]The theoretical assumption behind this argumentation "is that the free functioning of market forces leads to a better utilization and allocation of resources, guarantees a better satisfaction of the requirements of consumption and a bigger balance of foreign trade, and altogether produces higher economic growth and therefore development" (Strum 1998: 1).

a self-regulating entity. Alternative rhetoric to the Western welfare state regimes, which were facing difficulties in financing welfare provisions as a result of various economic crises, emerged. Ironically, the ideological and theoretical attack by neoliberalism on the state to replace it with market rationality led to the emergence of more authoritarian forms of the state, rather than its power being curbed (Bedirhanoğlu and Yalman 2010: 122).

In Turkey, the declaration of the January 24, 1980 stabilization program by the rightist Nationalist Front government marked the initiation of economic liberalization.[4] However, the government was incapable of implementing such an agenda of "reform" by remaining within the boundaries of the existing constitutional order, which provided some parts of society with rights and freedoms to protect themselves in the social and economic realms. In this respect, the September 12, 1980, military intervention paved the way for the establishment of a more authoritarian form of state that could quickly put the new economic policies into effect. In keeping the inner contradictions of the neoliberal policy orientations out of sight, the neoliberal discourse asserts that "the Turkish state remains by and large as dirigiste as ever. The terms 'liberal' and 'market-oriented' are quite misleading when used in connection with the Turkish reforms of the 1980s" (Rodrik 1995: 463). This discursive maneuver rests on a myth of the continuity of state tradition in Turkey, but neoliberalism emerged partly as a result of the "class-based" response to the crisis of the 1970s (Bedirhanoğlu and Yalman 2010: 107). The authoritarian form of state in Turkey had to overcome the resistance of the Turkish working classes in order to create a competitive market economy and integrate into the world economy. Following the 1980 military coup, "putting an end to class-based politics" emerged as the most crucial and strategic priority of the authoritarian regime which was to restructure the state (Yalman 2010: 308). Since we cannot fully understand such policy preferences without reference to class interests, we examine these interests in this study through elaborating on the transformation of the healthcare system in Turkey in neoliberal directions, from the perspective of a critical political economy which examines the state, the market, and their interrelationship.

The processes associated with neoliberalism, such as liberalization, deregulation, and privatization, have been taking place at differing paces and scopes across different sectors in Turkey. According to the standing 1982 Constitution, the Republic of Turkey is a welfare state. However, increasing socio-economic inequalities in Turkey emanating from the last forty years of experiencing neoliberal structural adjustment have revealed significant welfare issues. Notably, in the post-2001 crisis era, Turkey was marked by its assertive neoliberal market-oriented strategy of financialization (Yalman, Marois, and Güngen 2019: 16). The Justice and Development Party (AKP), which is the ruling party since the end of 2002, "may best be described, in social policy orientation, as an amalgam of neoliberalism with social conservatism" (Buğra and Keyder 2006: 213). Within this context, the AKP took the most striking steps towards neoliberalism in the sphere of healthcare, one of the essential welfare provisions of the state.

In this context, the primary purpose of this article is to analyze the neoliberal underpinnings of the HTP in Turkey. No one can make a genuine account of the changes in the healthcare system without referring to the transformation of the Turkish economy since the 1980s. If we consider the January 24, 1980, stabilization program to be the beginning of neoliberal policies in Turkey, the HTP of the 2000s seems to be a late component of the neoliberal transformation. This relative deferment of health transformation should not be considered separate from the historical background of the transition to neoliberalism in Turkey. The link between the general framework

[4]Since it was backed by the World Bank, IMF, and the OECD (Organization for Economic Co-operation and Development), the January 24 program should therefore be considered as part of a broader picture of neoliberal globalization (Senses 2016: 15). The main objectives of this program were "to remove the dominance of the state in key industries and in banking, and to minimize the state's intervention with the pricing and resource allocation processes of the market economy" (Taymaz and Yilmaz 2008).

of structural adjustment policies and "healthcare reform" must therefore be specified. With this aim in mind, we examine how the neoliberal welfare regime has affected both the provision of healthcare services and household healthcare expenditure in Turkey.

The literature on the health reforms in Turkey reflects two competing tendencies. The first group, ignoring the underlying political economy and therefore disregarding the class-based nature of the reform as a project of the bourgeoisie emanating from a strategy of global neoliberal capital accumulation, tries to find statistical bases for affirmation (e.g., Akdağ 2015; Atun et al. 2013; Başol and Işık 2015; Bostan, Çiftçi, and Bostan 2016; Çavmak and Çavmak 2017; Çelikay and Gümüş 2011; Kasapoğlu 2016; Koçak and Tiryaki 2011; Memişoğlu 2016; Mollahaliloglu et al. 2018; Sparkes, Atun, and Bärnighausen 2019; Tirgil, Gurol-Urganci, and Atun 2018). The second group focuses on one of the controversial issues of the healthcare service provision, and thus provides only a partial picture of the health system (e.g., Caner, Karaoglan, and Yasar 2020; Eren Vural 2017; Erus et al. 2015; Yardim and Uner 2018). Along with offering a comprehensive account of the transition to neoliberalism, this study contributes to the literature by analyzing the most significant problematic aspects of the Turkish health system.

2. Welfare Regimes and Framework of Health Reforms

The rise of neoliberal structural adjustment policies cannot be understood without considering the underpinnings of the welfare state that came to the fore following the Second World War. This period produced the necessary climate, at both national and international levels, to promote the profitability of private capital and was critical for the consolidation of the accumulation regime based on mass production and mass consumption. Domestic stability, and thus the curbing of left- and right-wing extremisms, was realized through a compromise between labor and capital in the post-war era. This compromise, also known as embedded liberalism, would replace the neoclassical commitment to the market as a self-regulating entity with state interventionism and recognize the social and political constraints to economic activity (Blyth 2002: 6; Jessop 2002: 73; Ruggie 1982: 393). In other words, the state was attributed a crucial role in the active public management of the economy (Helleiner 2019: 1117).

In the context of embedded liberalism, as Kane and Kirby (2003: 141) put it, "a welfare state is one in which the government intervenes in the workings of the economy to ensure a minimum income for all, and commits itself to provide essential services such as health care according to need." The Keynesian logic behind financing such a state relies on general taxation and national insurance payments (Kane and Kirby 2003: 146). Granting social rights to citizens for *de-commodification*[5] of their status in relation to the market is the core ideal of the welfare state (Esping-Andersen 2000: 157). Apart from this ideal, the welfare states also differ in their content regarding the arrangement between state, market, and the family. For example, Esping-Andersen's (2000: 162) typology of welfare regimes encompasses liberal, corporatist, and social-democratic welfare regimes. In the liberal welfare regimes of the United States, Canada, and Australia, means-tested (selective) assistance is a fundamental characteristic, in which needy people are provided with services and aid while the market is encouraged by the state. The corporatist welfare states like Austria, France, Germany, and Italy, which bear a corporatist-statist legacy and are shaped by the Church, are conservative in the sense that they attach importance to the family and traditional gender roles such as the male breadwinner model (Daly and Lewis 2018; Esping-Andersen 2000). In the social-democratic welfare regime seen in Scandinavia, the social rights-based

[5]According to Esping-Andersen (2000: 157), de-commodification can be realized "when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market." It acts to strengthen the workers vis-à-vis the employer.

(universal) provision of welfare and de-commodification are prominent principles (Esping-Andersen 2000: 162, 2017: 154).

By the late 1970s and early 1980s, "unemployment emerged for the first time as a major welfare state failure. There was widespread fear that governments were being overloaded with demands and responsibilities, that society had become ungovernable" (Esping-Andersen 1999: 2). When Keynesian logic faced a crisis in the second half of the 1970s, it is significant that it was a British prime minister from the Labor Party, not the Conservative Party, who questioned the very logic of public expenditure within the congress of his party. Prime Minister James Callaghan (1976: 24) said:

> We used to think that you could spend your way out of a recession, and increase employment by cutting taxes and boosting government spending. I tell you in all candor that that option no longer exists, and that in so far as it ever did exist, it only worked on each occasion since the war by injecting a bigger dose of inflation into the economy, followed by a higher level of unemployment as the next step. Higher inflation followed by higher unemployment. We have just escaped from the highest rate of inflation this country has known; we have not yet escaped from the consequences: high unemployment.

Through this line of argumentation, the neoliberal school of thought attacked all Western welfare state regimes because the cost of embeddedness for the upper echelons of the bourgeoisie had been burdensome with respect to their diminished shares of national incomes and restricted economic power. "Disembedding" the state from the market became the only alternative for the bourgeoisie in the wake of the crisis of capital accumulation, when growth collapse "affected everyone through the combination of rising unemployment and accelerating inflation" (Harvey 2005: 14–15). This crisis opened space for the neoliberals who, dating back to the 1940s had organized around a "thought collective" called Mont Pèlerin Society (MPS), to impose their arguments across the globe (Brown 2015: 20; Plehwe 2009: 3–4).[6] The neoliberal worldview therefore took root in everyday life by positing the market as the most potent information processor which was free of failure (Mirowski 2013: 28, 54). Drawing upon this utopian conception of the market, the Keynesian "class compromise" between capital and labor that had taken the form of welfare systems, exposed the need for a political project to restore both the conditions for capital accumulation and the power of capital in general, or finance in particular (Cahill 2014: 64; Harvey 2005: 11–19, 2016). To put it another way, once neoliberalism had emerged as a set of economic and political ideas of the MPS, and with the crisis of Keynesianism, it had come to be understood "as a material structure of social, economic and political reproduction underpinned by financialization" (Fine and Saad-Filho 2017: 686).

Although it derived from the stagflation of the 1970s, neoliberalism has managed to survive the great contraction which started in 2007. As Philip Mirowski (2013) puts it, neoliberalism owes its resilience despite the crises to the "double-truth" doctrine. The neoliberal thought collective makes use of the esoteric version of its doctrine for its closed elite, and the contradicting exoteric version for the masses. The first contradiction worth mentioning is about the role ascribed to the "disembedded" state. It was not a minimal state prescribed by classical liberalism but a strong state to initiate structural adjustment and banish resistance in an illiberal manner. The power of the capitalists is masked through "confusion of 'marketization' of government functions with the shrinking of the state" whereas "bureaucracies become more unwieldy under neoliberal regimes" (Mirowski 2013: 57).

Secondly, although society is attributed to a spontaneous order, namely the market, the strong state has relied heavily on regimentation as both producer and arbiter of a stable market economy

[6]Thought collective refers to a "multilevel, multiphase, multisector approach to the building of political capacity to incubate, critique and promulgate ideas" (Mirowski 2013: 44).

(Mirowski 2013: 72–73). While the narrative of spontaneous order serves to appeal to the masses through the mainstream media, the need to capture the state and reengineer it in the neoliberal direction was exclusively an esoteric doctrine of the intellectual project (Mirowski 2013: 77).

Thirdly, since "the difference between the knowledge that the wisest and the knowledge that most ignorant individual can deliberately employ is comparatively insignificant" in neoliberal thought (Hayek 1960: 376), a powerful attachment to market rationality as a superior information processor has resulted in the glorification of ignorance to help promote social order (Mirowski 2013: 78–83). Moreover, neoliberalism emerged as a governing political rationality which "extends a specific formulation of economic values, practices, and metrics to every dimension of human life" (Brown 2015: 30). This has led to the transformation of everything to capital, and the related banishment of labor as a category, as well as its collective form of class (Brown 2015: 38). The "economization of the political" has eliminated the compromising content of embedded liberalism and replaced the welfare state with individualized responsibility and technicalized governance (Brown 2015: 130).

This retreat of the welfare state was accompanied by an increasing emphasis on social policy, which focused on the conditions of low-income groups. Accordingly, neoliberal globalization pacified or tamed the potentialities of social policy, such as social protectionism, redistribution, and transformation. Instead, it presented an understanding of "social security networks" as a remedy to some market failures by reducing social policy to a vulgar economic/accounting problem in the absence of the "social" and solely under the heal of the "economic," isolated from wholesale social determinants (Yaşar and Yenimahalleli Yaşar 2012: 88). In this context, the fiscal crisis of the state not only limited the funds available for social expenditures but also increased the leverage of the IMF and the WB in the process of social security reform, mostly to reduce the budget deficit (Buğra and Keyder 2006: 212; Saritas 2020: 67).

With regard to healthcare, one of the three pillars of social policy along with education and social security, the neoliberal triad of anti-health reforms, government budget-cutting, deregulation, and privatization, were implemented (Terris 1999). "Public services (e.g., healthcare) are seen merely as products to be sold since the private sector can deliver better" and the citizens who had been the beneficiaries of public services financed by the welfare state then become customers to buy these products (McGregor 2001: 87). Parallel to this line of thinking, neoliberal restructuring of policies in the name of "healthcare reform" supported the free-market delivery mechanism of the for-profit system by presenting states as inefficient and private markets as more cost-effective and consumer-friendly (McGregor 2001: 82–83). Cost-cutting efficiency is therefore key to this neoliberal justification (Dent 2006: 450; McDaniel and Chappell 1999: 124).

At this juncture, in 1987, the WB published a report urging states to restructure their healthcare systems in order to cope with (1) insufficient spending on cost-effective health activities; (2) internal inefficiency of public programs; (3) inequity in the distribution of benefits from health services (WB 1987: 2–3). The WB proposed four complementary policy reforms as a recipe: (1) charging users of government health facilities; (2) providing insurance or other risk coverage; (3) using nongovernment resources effectively; (4) decentralizing government health services (WB 1987: 3–6). These reform recommendations became the conditions for receiving loans for developing economies and thus created "austerity for the working and middle classes, and prosperity for the rich and powerful" (Terris 1999: 153). The adjustment policies introduced new mechanisms for financing healthcare services "with a prevailing trend toward privatization and the transfer of operational costs to users" (Pan American Health Organization 1991). The real purpose of privatization, which was the most extreme component of marketization in the healthcare sector, was to provide global capital with new endeavors for accumulation and profit maximization.

However, a cross-national study on healthcare, conducted on behalf of the masses, showed: (1) threats to individual and family security by exposure to high out-of-pocket costs under neoliberal policy shifts; (2) difficulties in obtaining care; (3) fears of declining quality of care in the

United Kingdom, Canada, the United States, Australia and New Zealand (Donelan et al. 1999: 216). Moreover, catastrophic health spending became inevitable for low and middle-income families and individuals, which often turned into financial disasters as a result of increased out-of-pocket spending, as well as problems in accessing health and quality care. In the United States, for example, unaffordable medical bills make up a substantial share of all bankruptcy files (Himmelstein et al. 2019; Khera et al. 2018).

It has become evident that the neoliberal reform agenda to sustain economic growth by limiting the public provision of healthcare services has resulted in adversely affecting the health of the population. "Long-term prosperity seems to be no more than a necessary, although still insufficient, condition for improvement in the population's health, indicated by reduced health returns of economic growth at higher levels of prosperity" (Nelson and Fritzell 2014: 64).

3. The Turkish Experience

Some social policy specialists are critics of the social security systems linked to employment status since these systems fail to provide socioeconomic security for the poor and contradict the realities of the labor market (Buğra and Keyder 2006: 219). To illustrate, before the unification of the Turkish public insurance schemes in 2008, there were three mandatory social health insurance schemes based on status differentiation and financed by the contributions of employers and employees. In this public insurance system, access to healthcare and formal employment were mutually inclusive. This meant that a significant proportion of the population did not have health insurance since informal employment was widespread. In order to cope with this problem and reduce the cost of access to healthcare services for those not covered by health insurance, a means-tested public health insurance program, the Green Card, was introduced in 1992. Dwelling on the ramifications of the Turkish social security system, Buğra and Keyder (2003: 13–14) argue that Southern European countries, together with Turkey, do not fit into Esping-Andersen's three-fold typology of welfare regimes. They suggest it is necessary to add the "Southern European welfare regime" as a fourth category. They define the distinctive characteristics of the Turkish social policy environment as having conservative and corporatist roots and reflecting familialism and clientelism (Buğra 2012: 18; Buğra and Candas 2011: 516–17). However, their categorization relies heavily on "a rather futile comparison with the European welfare regimes of a by-gone era" (Yalman 2011: 235). Indeed, they (1) rule out capitalism and class from their analyses; (2) concentrate on the symptoms of poverty rather than its causes; (3) overlook the impact of financialization on wage-laborers; (4) dismiss the possibility of bringing in the politics of redistribution; (5) provide tacit legitimation of the neoliberal welfare regimes (Yalman 2011). Rather than adopting such a framework of social policy, we put emphasis on understanding the nature of the neoliberal restructuring and its relevance to the HTP.

Looking at the journey of neoliberalism in the last few decades, we see that the Turkish healthcare system has been undergoing a process of transformation parallel to the modality offered by the structural adjustment rhetoric. The Fundamental Law on Healthcare Services in 1987 was the first concrete step, and health reform which emphasized cost-limiting policies remained on the agenda up until the end of the 1990s (Erol and Özdemir 2014: 11). In 1990, the State Planning Organization prepared a master plan for the health sector, and this plan provided the scope of reform strategies (Belek 2001: 438). Following the first US $75 million health policy loan agreement with the WB in 1990, the MoH worked through healthcare reform efforts covering regulations on financing, restructuring, service delivery, health management, and health information systems with the principles of efficiency, accessibility, and equality (WB 1990). The topics of the neoliberal reform framework were discussed in the First National Health Congress (MoH 1992). In 1993, the Health Reform Draft Law was based on the introduction of family practice model as a means of privatization of primary healthcare services, the privatization of public hospitals and

transition to general health insurance, and the authorization of local forces in healthcare services (Madenoğlu Kıvanç 2015: 165). The 1996 Healthcare Reform Proposal also supported a purchaser-provider distinction and the creation of a public fund, including uninsured persons, who were expected to contribute in proportion to their income (Agartan 2015: 976). All these efforts and rhetoric culminated in the WB report titled *Turkey: Reforming the Health Sector for Improved Access and Efficiency* (WB Human Development Sector Unit 2003).

In 2003, the MoH issued a booklet on the "Health Transformation Program," "whose inspiration derived from World Bank reports" (Buğra and Keyder 2006: 216). During the long-standing rule of the AKP, fields like financing healthcare, service provision, salary system, forms of employment, public health institutions, and private hospitals have been restructured within this program (Öztürk 2017: 404).

The HTP not only transformed the corporatist nature of the Turkish welfare regime based on "status-differentiating" welfare programs but also extended the demographic scope of the healthcare system. For example, since 2012, within the newly introduced General Health Insurance (GHI) scheme, people have to pay varying premiums determined by the household income levels. If the applicant's per capita household income is less than one-third of the gross minimum wage, the state subsidizes the premium of the person who cannot afford their premiums, and, like the Green Card mechanism, they can still access healthcare if they pass the administrative means-testing. Those who fail to pay health insurance premiums cannot be covered by health insurance and therefore do not have the right to receive any healthcare services free-of-charge. They will also be indebted to the Social Security Institution (SSI) by the amount of the premium (Erus et al. 2015: 100).

Primary healthcare services used to depend on the healthcare centers that integrated prevention and treatment services on regional and teamwork bases. With the HTP, the health centers left the ground to the family practice units composed of a family physician and a family health employee. As stated in the booklet, these new units were, at first, planned as the first stage of a compulsory referral chain between different service stages (MoH 2003: 31). Nonetheless, due to the reactions of the patients, this objective has been postponed (Öztürk 2017: 404). The results of the family practice units so far are the closure of thousands of state-owned healthcare centers and change of the statutes of the healthcare personnel to contractual employment without job security, as opposed to public employment with full benefits (Turkish Medical Association 2018: 472).

A retrospective interpretation of the correlation between these new policies and the lack of significant improvement in the level of health of the Turkish population makes the underlying neoliberal reform program controversial. While the expected life expectancy at birth increased by 2.3 years in the decade following the initiation of the HTP (2003–2012), the increase observed in the decade before HTP was introduced (1993–2002) was 3.4 years (OECD 2020). The infant mortality rate dropped from 53 to 29 per thousand in the decade before HTP and 13 per thousand in the decade after HTP (Institute of Population Studies 2014: 132). The change in the expected life expectancy at birth and the infant mortality rate has been stagnant since then. In other words, the constant decrease in the infant mortality rate and the steady increase in life expectancy since 1978 cannot be entirely attributed to the HTP (Aktan, Pala, and Ilhan 2014: 25). In terms of spatial dependence, the average rise in the level of health outcomes reflects the pattern of rising inequalities between regions of Turkey (Karahasan and Bilgel 2017: 9). Despite the limited rise, which has been unequally dispersed, life expectancy at birth, infant mortality rate, the scope of social security related to health, immunization rates, infectious diseases, screening programs, and healthcare quality indicators are still far behind developed countries. In terms of health resources that have a direct impact on health outcomes, Turkey has the lowest healthcare spending level as both per capita and share of the GDP, as well as the smallest numbers of practicing doctors and nurses per 1000 population among the OECD countries (OECD 2019: 32).

Alongside the negligible progress in population health outcomes, the healthcare system in Turkey reflects five significant problematic aspects within the context of transformation. These

are public-private partnerships; the marketization and financialization of healthcare services; consolidation and concentration in the private provision of care; out-of-pocket expenditures; and public procurement. These problematic aspects of the Turkish healthcare system raise serious equity concerns. The following sections discuss these points one by one.

3.1. The public-private partnership (PPP)

The AKP presented public-private partnerships as a unique model implemented in the Turkish healthcare system. However, the PPPs in health and education were one of New Labor's most controversial approaches to the public provision of welfare services in the United Kingdom (Kane and Kirby 2003: 171). The PPPs contributed to fiscal reforms (a component of neoliberal structural adjustment) by dwelling on a public accounting trick in which the government pretended it was not spending, while private companies within the PPP appeared to be the ones borrowing and spending (Öncü 2018: 18–19). It has been argued that the risk of "overspending" by the government could be shifted onto the private sector through the PPPs; however, contrary to the neoliberal political rhetoric, actual experience proves that costs were increased by this model since public sector organizations can borrow more cheaply than private companies (Kane and Kirby 2003: 171–73; Öncü 2018: 30; Pala 2018b: 7–8). Pala (2018b: 8) refers to data provided by the European Investment Bank which indicate that, with this model, investment costs are 24 percent higher than classical public tenders, and the loans to finance the projects are 83 percent more expensive than public borrowing. In addition to these rising investment costs, the government may be in the position of paying more if their private partners get in trouble. For example, in the United Kingdom, when one of the largest supplier companies with approximately 450 procurement contracts with the state went bankrupt in 2018, the government had to provide additional financial resources to maintain public healthcare services (Pala 2018b: 8). The UK experience strongly indicates the risks and inefficiencies of this model (Pollock 2000, 2004; Öncü 2018: 19). Even an IMF working paper could not help but admit the failure:

> Both traditional procurement and PPPs share common project risks, such as construction and demand risks. However, the government bias and possible manipulation of PPPs add an important layer to the common project risks. An inadequate budgetary and/or statistical treatment may allow governments to ignore the impact of PPPs on public debt and deficit. In practice, governments often end up bearing more fiscal costs and risks than expected in the medium and longer term. (Jin and Rial 2016: 23)

Consequently, while private sector capital accumulation increases as a result of governments becoming trapped in greater spirals of debt to private banks, it is passed to individuals through regressive taxation, cuts in social services including healthcare, and transfers such as increased out-of-pocket expenditures.

Despite its proven weaknesses in the United Kingdom, in Turkey the "public-private partnership" model, named as "city hospitals," was proposed as a version of the build-operate-transfer model in which the building and maintenance of healthcare facilities are done through private investment in return for service and usage charges during the term of the contract. The government also guarantees 70 percent bed occupancy rates in city hospitals (Pala 2018b: 10). Thus in Turkey, the state has to shoulder the demand risk, which was being borne by the private sector in the PPP practices of the developed countries (Çal 2018: 52). This model is seen as a new way of privatization and funds transfer to global capital in the Turkish healthcare sector (Pala 2018b: 12). Although officials do not announce the rental values and accounts of facility building costs, using the fact that they are "trade secrets" as justification, calculations by the Turkish Medical Association show that there is a vast sum of public loss (Öztürk 2017: 405). For example, in the eight out of 12 investments in 2012 for which information could be reached, the difference between the envisaged

constant investment amount and rental charges for 25 years (the duration of the contracts), apart from the service procurement costs, indicates that the amount of public loss was TRY 26.5 billion (Öztürk 2017: 405). Besides, based on a report from the Ministry of Development, Pala (2018b: 10) notes that the state is expected to pay US $30.3 billion for renting 18 city hospitals for the next 25 years. It is also stated that US $2.6 billion worth of funds have been allocated from the national budget to compensate for the guaranteed losses of the four completed city hospitals. This shows that the claim of reducing public spending over PPPs is a financial myth. Sönmez (2018: 67–69) predicts that this myth is creating a giant black hole in future budgets.

3.2. Marketization and financialization of healthcare services

We can define marketization in reference to the integration of competition and price mechanisms into public services, and privatization as the most dramatic form of marketization (Bevir 2009: 128). In an environment of marketization through the neoliberal HTP, the Turkish private hospital chains with significant economies of scale advantages seem to have attracted global investment in the form of share acquisitions by global private equity funds. Hence, marketization and financialization of the healthcare services go hand in hand. There are three dimensions of marketization that have paved the ground for financialization in Turkey:

> First, public provision and financing of health care services were separated, which intensified market type exchange relations in health care. Public health care financing was unified under the newly-founded single public payer, the SSI. Second, public hospitals were turned into public enterprises funded on the basis of performance, and they started to compete with the bourgeoning private providers in service provision. Finally, the development of private health care provision was encouraged. In particular, the procurement of health care services by the newly-founded single public payer, the SSI, from both public and private health care providers generated a regular financing mechanism for private health care providers, increased access to private health care through public financing, and generated increased demand for and growth in private health care provision. The initiation of the GHI system in 2012 further expanded the scope of public procurement of health care services from the private sector and institutionalized its means. (Eren Vural 2017: 279)

Financialization, as Epstein (2005: 3) puts it, refers to "the increasing role of financial motives, financial markets, financial actors, and financial institutions in the operation of the domestic and international economies." In other words, neoliberalism has consolidated the power of, what Marx calls, fictitious capital over real accumulation and has integrated the latter into the realm of interest-bearing capital (Ashman, Fine, and Newman 2011: 176).

Similarly, the neoliberal reform agenda has reinforced the spread of financialization in the Turkish healthcare system as there has been an accelerating reliance of the Turkish economy's growth prospects on capital flow (Yalman 2019). More putatively, the HTP, rather than being a domestic project of the national elite, is the product of a "subordinated financialization" (Lapavitsas and Powell 2013: 364), shaped from the outside, in line with the peripheral interests of international finance settled in the core countries. In this regard, the investment of global private equity funds in the Turkish private hospital sector is one of the leading indicators of financialization. These investments have had four impacts on the further marketization of healthcare as they have (1) fortified concentration in the healthcare sector by helping the chain formation processes of some private hospitals; (2) consolidated the financial mindset of calculating in the operations of private hospitals; (3) helped local capital to become internationalized; (4) together with the 2008 global financial crisis, increased existing inequalities in accessing healthcare by extra-billing (Eren Vural 2017: 277).

What Bakker and Gill (2003: 19) once called the "privatization of social reproduction" has become the financialization of social reproduction with these neoliberal impacts on the Turkish

healthcare system. In the Turkish context, on the one hand, as İpek Eren Vural (2017: 278) notes, there are devastating outcomes of the financialization of social reproduction: Firstly, the fluctuating nature of the financial markets pose a threat to the sustainability of public welfare services. Secondly, the income of the middle and working classes is transferred to the financial sector, and the commodification of labor-power which was once aimed at de-commodification by welfare state measures, is intensified. Thirdly, the financial sector not only gains disciplining power and secures compliance in relation to labor but also to other fractions of capital. On the other hand, the future of the Turkish healthcare system in terms of financialization seems bleak, according to *The Venture Capital and Private Equity Country Attractiveness Index 2018*, in which Turkey lost five ranking positions in the 2014–2018 comparison and was categorized as having "decreasing attractiveness" (Groh et al. 2018: 23). Likewise, since the legalization of private equity funds in 2014, the share of financial investor deal activity decreased to its lowest level in 2018 and made up only 8 percent of the total annual deal volume in Turkey (Deloitte Turkey 2019: 8–9).

3.3. Consolidation and concentration in the private provision of care

In 2008, the government also helped private hospital chains attain concentration and containment of competition by issuing new regulations which restricted hospital operation licenses and required new technologies and medical personnel for private hospitals (Eren Vural 2017: 279). The regulations negatively affected smaller private hospitals and facilitated hospital chains. As a result of this, the number of beds in the largest five hospital chains increased from 6 percent to 20 percent between 2009 and 2013 and 28 percent in 2015, while small providers were kicked out of the market (TOBB Healthcare Providers Industry Council 2017: 17). Government support can be seen in its procurement of healthcare services from private providers as well: While in 2008 the SSI allowed private hospitals to bill patients up to 30 percent of the service prices covered by the SSI, this percentage increased to 70 percent in 2010, 90 percent in 2012 and 200 percent in 2013. The government has softened sanctions for private hospitals that exceed the upper limit of extra-billing, and up until now, although there is a significant amount of abuse, there is no hospital that cannot renew its contract with the SSI for violating the upper limit rates (Öztürk 2017: 407). As shown in table 1, the rise in the number of private hospitals, number of beds in private hospitals, and referrals to private hospitals, compared to public and university hospitals, display the degree of marketization in the Turkish healthcare system before and after the HTP. Table 1 also indicates that the capacities of public healthcare institutions (number of beds) have not increased parallel to the demand for these institutions (number of referrals).

In appearance, neoliberal healthcare policies have extended services to larger segments of society by increasing expenditures in health. However, these policies have left the practice of service provision to private firms and hospitals to a large extent. While primary services remain in family practice units, the state has sponsored the private sector for secondary care, which is more profitable.

3.4. Out-of-pocket expenditures

In order to account for out-of-pocket expenditures in Turkey, an analysis of data given in table 2 suggests that the share of household health expenditures decreased from 20 percent to 17 percent while the share of household health expenditures within private health expenditures increased from 68 percent to 78 percent. However, the rate of increase in public health expenditures is much higher than the rate of increase in household health expenditures. This stems from the transfer of public funds to the private sector by public procurement of healthcare services from the private sector. Thus, the decrease in the share of household health expenditures within the total health

Table 1. The Number of Hospitals, Hospital Beds, and Referrals to Hospitals in Years 2002 and 2017.

	Hospitals			Hospital Beds			Referrals		
	2002	2017	Increase	2002	2017	Increase	2002	2017	Increase
Ministry of Health	774	879	13.6%	107394	135339	26%	109793128	353703814	222.2%
University	50	68	36%	26341	41324	56.9%	8823361	38963933	341.6%
Private	271	571	110.7%	12387	49200	297.2%	5697170	91121444	1599.4%
Other	61			18349					
Total	1156	1518	31.3%	164471	225863	37.3%	124313659	483789191	289.2%

Source: Authors, based on data from the MoH (2019).

Table 2. Inflation-adjusted Health Expenditures in Turkey between 2002 and 2017 (TRY Million).

Year	Total	Public	Private	Household	Household/ Private	Household/ Total
2002	18774	13270	5504	3725	68%	20%
2003	20575	14798	5777	3798	66%	18%
2004	27454	19560	7893	5281	67%	19%
2005	32824	22267	10556	7472	71%	23%
2006	40190	27465	12725	8831	69%	22%
2007	46963	31857	15106	10245	68%	22%
2008	52462	38305	14155	9118	64%	17%
2009	54361	44015	10345	7642	74%	14%
2010	57968	45565	12402	9456	76%	16%
2011	62115	49416	12700	9588	75%	15%
2012	69884	55373	14510	11068	76%	16%
2013	78575	61664	16910	13180	78%	17%
2014	87593	67839	19754	15548	79%	18%
2015	96101	75471	20628	15913	77%	17%
2016	110343	86623	23720	18024	76%	16%
2017	125667	98055	27612	21447	78%	17%

Source: Authors, based on the nominal data from the Turkish Statistical Institute (2019).

expenditures does not indicate any decrease in out-of-pocket expenditures. On the contrary, the cost of healthcare services both for the public and for households has risen with the HTP.

Real out-of-pocket health expenditures per capita at the 2018 price level in TRY rose from 247 to 352 between 2002 and 2018 (MoH 2019). It is a common characteristic of neoliberal healthcare reforms to change the financing structures of public hospitals by reducing the share of allocation of funds from the national budget and increasing the shares of private/public insurance funds and out-of-pocket expenditures (Pala 2018a: 111).

A study based on the 2002–2003 National Health Accounts Household Expenditure Survey evaluates taxes, social security premiums, and out-of-pocket expenditures as the financing sources of the Turkish healthcare system (Sezer and Özsoy 2017). The study indicates that financing healthcare services in Turkey is regressive, thus inequitable because indirect taxes and out-of-pocket expenditures are too high. The most prominent indications of rising out-of-pocket expenditures are increased health expenditures and decreased health status (Özgen Narcı, Şahin, and Yıldırım 2015: 255). Although the Turkish healthcare system has undergone significant changes since 2003, the financing sources and their share within the total healthcare expenditures, except for out-of-pocket expenditures, stand the same as there has been no change in the financing of the healthcare system. However, it has been imperative to make a payment to health institutions at every level of the healthcare system since 2003. The number of these have increased, and contribution rates towards getting medicine have also risen (Sezer and Özsoy 2017: 207). Tables 2, 3, 4, and 5 show rising out-of-pocket expenditures of the SSI beneficiaries for outpatient examinations, prescription, treatment tools and equipment, and outpatient medication from 2002 to 2018. As a result of these, scholars estimate that the share of out-of-pocket expenditures has increased since 2003 (Cinaroglu and Baser 2019: 304; Sezer and Özsoy 2017: 207). For Erus and Aktakke (2012), as a result of the inclusion of private providers in the public insurance scheme, the share of out-of-pocket expenditures for more affluent households has decreased, while the lower-income groups have been adversely affected. Another survey also shows that the lower-income groups have to shoulder the greater financial burden in terms of increasing out-of-pocket expenditures (Özgen Narcı, Şahin, and Yıldırım 2015: 268). However,

Table 3. Out-of-Pocket Payment for Healthcare Providers (Contribution/User Fees for Outpatients).

	Application Fees for All SSI Beneficiaries	
Healthcare Providers	2002	2018
Primary care (family physicians)	No fee	No fee
Secondary care (public hospitals)	No fee	TRY 6
Tertiary care (research public hospitals)	No fee	TRY 7
Tertiary care (university hospitals)	No fee	TRY 8
Private hospitals (if the SSI procure healthcare service from private healthcare providers)	Not provider for SSI	SSI fee: TRY 15 In addition to SSI fee, private hospital procures extra-billing patients up to 200% of SSI's service prices

Source: Authors, based on data from the service price index issued by the SSI (2019).

Table 4. Out-of-Pocket Payment for Medication (Drugs), Treatment Tools, and Equipment.

Medication (Drugs), Treatment Tools, and Equipment	Contribution Fees	
Type of beneficiary	2002	2018
Active contributors and their dependents	20% of the cost	20% of the cost
Passive members and their dependents	10% of the cost	10% of the cost
Green cardholders		10% of the cost

Source: Authors, based on data from the service price index issued by the SSI (2019).

Table 5. Out-of-Pocket Payment for Prescriptions.

Prescription	User Fee for All SSI Beneficiaries	
According to unit prescribed	2002	2018
Per prescription, including max. 3 unit	No fee	TRY 3
Per additional unit in the prescription	No fee	TRY 1

Source: Authors, based on data was from the service price index issued by the SSI (2019).

other researchers assert that "the burden on the poor is outweighed by the new benefits they gain" (Hazama 2015: 38). For example, the extension of the Green Card scheme in 2004 from initially covering only inpatient care to outpatient care and medication is an essential benefit to the poor.

Table 3 shows that beneficiaries are obliged to pay the hospital usage fee which changes in accordance with hospital type and contribution fees for the treatment tools and equipment used. Although the application to family practice units (primary care) is exempt from the hospital usage fees, patients pay an application fee at an increased rate according to their application to public hospitals (secondary care), to research/university hospitals (tertiary care), or private hospitals. The rate of application fee to private hospitals has been kept at a maximum level, and it has become legally permanent to charge SSI beneficiaries an additional fee of up to 200 percent of the SSI package price of these hospitals. Moreover, an additional fee was also imposed on the healthcare services offered to patients by faculty members in university hospitals (SSI 2019).

Another indicator of the increase in out-of-pocket expenditures is that the SSI increased the contribution of beneficiaries compared to practices before 2003. As shown in table 4, all individuals covered by social security paid only a share of the medication (drugs) before the HTP.

While the share of the drug contribution fee was 20 percent for employees and 10 percent for retirees, green card holders started to pay a 10 percent contribution fee with the HTP.

Besides this, all patients are charged fees for each prescription. As shown in table 5, patients are required to pay TRY 3 for up to 3 drugs per prescription, and an additional fee for each drug is added to the same prescription. Although there is no application fee for family practice units, patients pay contribution fees for the prescription of the family physician and also for the cost of the prescribed drugs.

3.5. Public procurement

The tracks of rent-seeking behavior of the Turkish bourgeoisie have taken different forms during the single-party governments of the AKP, not only in the healthcare sector but also in general terms of public procurement. It has been argued that accumulation via appropriation of public entities, rent creation, and appropriation of the created rent to enable strategic distribution to the supporting base of the ruling party are the most critical pillars of the continuity of the AKP (Çeviker Gürakar 2018: 13). The three building blocks of these pillars are as such: (1) different from the previous governments, the AKP creates rent by enacting laws rather than benefiting from any lacunae in law; (2) the AKP delivers this rent to those private firms which have direct political links or indirect relations to the party in a clientelistic manner; (3) the AKP creates new forms of resource allocation to its electoral base at the local level (Çeviker Gürakar 2018: 14). The politically linked or related firms are incorporated in the system of increasing satisfaction levels of the electorate through "philanthropic" activities, while the local governments specify the target group to benefit, and the Islamic NGOs which deliver the aid (Çeviker Gürakar 2018: 14). The neoliberal transformation of the Turkish healthcare system during the AKP rule is concomitant to this strategy of the party and rent-seeking behavior of the bourgeoisie.

3.6. Equity concerns

On the one hand, market-oriented practices have helped transfer funds to the private sector and strengthened the market logic, such as competition for clients and finance within the Turkish healthcare system. On the other hand, policymakers and some scholars argue that the HTP is based on "a rights-based philosophy" (Atun et al. 2013: 71). However, rather than selectivism, a rights-based philosophy brings universalism in its wake. As seen in the practice of the GHI, a means-tested approach is an essential component of "universal" health coverage in Turkey. Also, the reliability of implementing the GHI, through which the premiums of the poorest segments of society are to be subsidized by the national budget to overcome the equity concerns of neoliberal healthcare reforms, is controversial not only in Turkey but also in other countries undergoing similar transformations (e.g., Homaie Rad et al. 2017; Rotarou and Sakellariou 2017; Ortega and Orsini 2020; Plamondon 2020; Forster et al. 2020; Viens 2019; Amorim et al. 2019). For example, researchers argue that a significant amount of non-take-up of the GHI (Green Card) scheme indicates large out-of-pocket health expenditures, "and for a considerable number of households these expenditures reach as high as 20 percent of their total annual income" (Erus et al. 2015: 100). The existence of a large proportion of the poor population lacking coverage overshadows the rights-based philosophy.

As Osman Öztürk (2017: 409) maintains, firstly, patients today are no longer able to access a range of services from public healthcare institutions, and they are forced to buy those services from private healthcare institutions, not out of choice but in a compulsory manner. Table 1, which shows the difference between the increase in capacities of public hospitals and the increase in demand, suggests that people are directed to private hospitals not by free-choice but out of desperation. Secondly, the public nature of the healthcare system has been eroded with the HTP, and although the ownership structures remain the same, public healthcare institutions have been

forced to think in market terms. The two phenomena show that the healthcare system in Turkey has been exposed to a transformation in line with privatization. Thus, health is being commodified, and healthcare is used to accumulate capital. Despite paying the social insurance premium, in addition to taxes, patients are increasingly forced to meet healthcare expenditures through out-of-pocket payments.

4. Conclusion

This article has analyzed the repercussions of changes in welfare regimes in line with neoliberal restructuring policies on the healthcare sector. It argues that the Turkish experience, which is part and parcel of a global project, reflects vibrant examples of neoliberal restructuring through the initiation of the Health Transformation Program in 2003. In concluding remarks, firstly, the rent-seeking characteristic of the Turkish bourgeoisie has been nourished by the transfer of public funds to the private sector. Secondly, the Turkish welfare regime relies substantially on the family that "plays a dominant role in providing care for its dependents" and on the cover of healthcare expenditures on a partial and limited basis (Akkan 2018: 72). Thirdly, promoting the PPP model in the building and maintenance of healthcare facilities has increased the burden on the budgets of today and the future. Fourthly, the financialization in the Turkish healthcare system has threatened the sustainability of public welfare services and intensified the commodification of labor-power. Finally, the financial burden of healthcare services, especially on middle and lower-income groups in Turkey, has dramatically increased with rising out-of-pocket expenditures. In turn, their dependency on consumer credit to cover these increasing expenses leads to further financialization and economic inequalities (Karaçimen 2014: 168).

In an optimistic scenario, the state would have the resources to maintain the transfer of funds to the private sector and would share the burden of the financialization, marketization, and privatization of healthcare services on middle and working classes in Turkey. However, in a more realistic scenario, following a gradual withdrawal of the public from the provision of healthcare services, those classes would probably get used either to passing heavy means-tested procedures, achieving qualification as deserving of public assistance in healthcare, or purchasing the necessary services from the private sector. The following question may provoke a gloomy forecast: in the wake of rapid privatization in the healthcare system, what would happen if the SSI does not or cannot renew its contracts with private healthcare institutions?

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