CONTEMPORARY HEALTHCARE POLICIES AND THEORIES IN TURKEY

by

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CONTEMPORARY HEALTHCARE POLICIES AND THEORIES IN TURKEY

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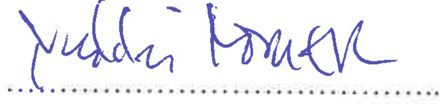

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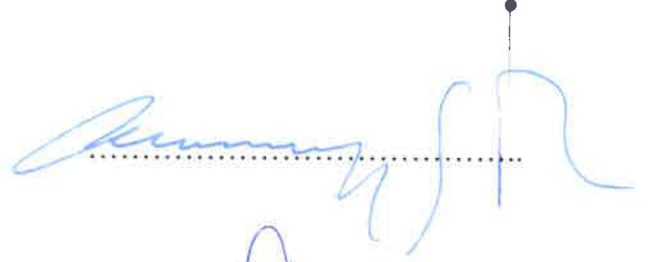

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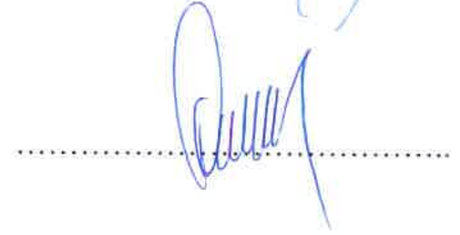

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ABSTRACT

CONTEMPORARY HEALTHCARE POLICIES AND THEORIES IN TURKEY

BİLGE KAAN TOPÇU

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Thesis Supervisor: Asst. Prof. Nedim Nomer

Keywords: Healthcare Policies, Patient Empowerment, Isomorphism, Stewardship Theory

This thesis aims to analyze the radically changing healthcare policies in Turkey in the period from the beginning of the 2000s until today and discover the contemporary theories to analyze these policies. The welfare state debates that began in the 1980s within the framework of neo-liberal policies gained a new dimension with the concept of the governance that is prescribed by international organizations such as the World Bank, the International Monetary Fund and the European Union. In the thesis, the Health Transformation Program, which was formulated by the Justice and Development Party according to the governance theory immediately after the 2002 elections and put into effect in cooperation with international organizations, is considered as the fundamental transformation dynamics affecting the contemporary healthcare policies. The effects of current health policies on patients, doctors, and institutions are discussed in the context of the policymaking process of the Health Transformation Program. With Systematic literature review method used in the thesis, data on the transformation of health policies were compiled while the effect of the transformation in health policies on the patient-doctor relationship was examined at the discourse level. In this context, contemporary healthcare policies in Turkey are discussed under the framework of patient empowerment, isomorphism, and stewardship theories.

ÖZET

TÜRKİYE'DE GÜNCEL SAĞLIK POLİTİKALARI VE TEORİLERİ

BİLGE KAAN TOPÇU

TÜRKİYE ÇALIŞMALARI YÜKSEK LİSANS TEZİ, KASIM 2019

Tez Danışmanı: Dr. Öğr. Üyesi NEDİM NOMER

Anahtar Kelimeler: Sağlık Politikaları, Hasta Güçlendirme, İzomorfizm, Vekilharçlık Teorisi

Bu tez 2000'li yılların başından günümüze Türkiye'de radikal bir biçimde değişen sağlık politikalarını incelemeyi ve bu politikaları incelemek için güncel teorileri ortaya çıkarmayı amaçlamaktadır. Neo-liberal politikalar çerçevesinde 1980'lerde başlayan refah devleti tartışmaları Dünya Bankası, Uluslararası Para Fonu ve Avrupa Birliği gibi uluslararası örgütlerin yönetişim kavramı çerçevesinde yeni bir boyut kazanmıştır. Tezde Adalet ve Kalkınma Partisi'nin 2002 seçimlerinin hemen ardından yönetişim teorisine göre formüle ettiği ve uluslararası örgütler ile işbirliği içerisinde yürürlüğe koyduğu Sağlıkta Dönüşüm Programı güncel sağlık politikalarını etkileyen temel dönüşüm dinamiği olarak ele alınmıştır. Güncel sağlık politikalarının hastalar, doktorlar ve kurumlar üzerine etkileri Sağlıkta Dönüşüm Programının politika yapım süreci bağlamında ele alınmıştır. Tezde kullanılan sistematik literatür taraması metodu ile sağlık politikalarındaki dönüşüme ilişkin veriler derlenirken sağlık politikalarındaki dönüşümün hasta-doktor ilişkisine etkisi söylem düzeyinde incelenmiştir. Bu bağlamda Türkiye'de güncel sağlık politikaları hasta güçlendirme, izomorfizm ve vekilharçlık teorileri çatısı altında tartışılmıştır.

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LIST OF ABBREVIATIONS

EU: European Union

HTTP: Health Transformation Program

JDP: Justice and Development Party

IMF: International Monetary Fund

MoH: Ministry of Health

OECD: Organization for Economic Cooperation and Development

WB: World Bank

WHO: World Health Organization

1. INTRODUCTION

The Justice and Development Party (JDP) government launched the "Health Transformation Program" (HTP) in 2003 in Turkey. The HTP imported various neoliberal reforms into the healthcare system in Turkey. While the patient satisfaction ratios are increased by introducing new technological applications such as "e-pulse" (e-Nabız) and "Central Doctor Appointment System", working models, employment conditions, and payment systems of doctors have changed via governance related laws and legislation. Thus the power relations among main stakeholders of healthcare policies have shifted. Although 'Healthcare policies' are a component of national public policy framework, in the case of transformation in Turkey's healthcare policies, impacts of international and supra-national organizations are observable. Indeed, the change of the organizational structure of the healthcare institutions could be associated with the inducements of certain international organizations such as the World Bank (WB), the World Health Organization (WHO), and the EU (EU). Hence, the HTP has mutilated healthcare policies in terms of agency and institution in last recent two decades.

1.1. Subject of Thesis

In the literature of healthcare politics, the HTP has studied from different analytical perspectives. Neoliberal transformation of healthcare system, commodification of healthcare services, and the quality-based outcomes of the HTP are the most prominent topics in literature (Ağartan 2005; Keyder et al. 2007; Ulutaş 2011; Bostan 2013; Cevahir 2016; Bostan and Çiftçi 2016; Yılmaz 2017). In these studies, although the meta-theories related to political economy were discussed in terms of the results of the transformation, micro theories explaining the transformation process were not examined in the context of

changing natures of relations among patients, medical specialists, and institutions. In other words, the literature does not provide a sufficient theoretical framework for explaining how patients and doctors are adapting to the transformation of health policies. The healthcare politics literature discusses the structural transformation of the welfare state because of its interaction with neoliberal policies, and criticizes the commodification of the right to health. However, it has a theoretical gap in explaining the increase in the satisfaction rates of patients, who have been subjugated to commodification of healthcare and how doctors maintain their occupational commitment even though they have been exposed to detrimental effects of neoliberal economic policies. Therefore, drawing from the existing literature on the Turkish healthcare system and its transformation, this thesis aims to attach the contemporary theoretical approaches to transformation process of healthcare policies in contemporary Turkey.

1.2.Methodology of the Thesis

In this thesis qualitative research methods are used. The thesis is formed by the systematic literature review. For the aim of establishing theoretical background of transformation in healthcare policies, mainstream approaches toward transformation of healthcare policies in global, regional, and local contexts and official findings on the HTP are systematically reviewed and synthesized. Theoretical approaches from disciplinary areas close to health policies such as medical sociology, organizational behavior, and international relations were examined in the context of health transformation program. Associated with this methodology, official documents and reports from different national and international organizations regarding the healthcare policy-making process in contemporary Turkey are analyzed (WHO 1998; WHO 2000; World Bank 2003; Akdağ 2007; 2009; OECD 2014).

Epistemological Positionality

One can possibly argue that the leverage of a thesis, especially if there is certain feasibility to conduct quantitative research to collect data, should depend on quantitative

or statistical knowledge to test its hypothesis. Researchers using quantitative data sets to produce information opposes to qualitative research methods in the context of "validity" of research results (Seidman 2006, 23). Likewise, the definition of qualitative research methods has been evaluated as just underpinnings for quantitative methods (Flick 2007, 44). My epistemological positionality in this point evaluates these critiques as old-fashioned approaches. These critiques take objectivity as vital componence of research and they underestimate the importance of case studies and qualitative research methods. However, in this study, my epistemological stance is prioritizing being critical.

As it is argued above, in the literature of healthcare policies in Turkey, there is a gap or a shortcoming of theoretical basis in various studies. To fill this gap, as a qualitative research methodology, the systematic review method provided a way of collecting necessary data (even statistical) and synthesizing previous researches with the contemporary and inter-disciplinary theoretical approaches (Snyder 2019, 333). However, this study has not the motivation of testing or reproducing already manifested hypotheses, in contrast to that, it attempts to inter-relate theories dealing with the different stakeholders of healthcare policies in terms of the HTP.

Research Motivation

Apart from developing a master thesis, this study has its own academic motivation. The reason of studying this subject matter engages with being a citizen of Turkey and a stakeholder of the healthcare system of Turkey. It has been a very obvious and unfortunate fact that violence against doctors in Turkey's healthcare system has become a usual incident in contemporary everyday lives of us (Durur 2017, 48). According to the results of the survey conducted by the Health and Social Workers Union in 2013 with 1300 health workers, 50.7% of the participants stated that they have been exposed to different types of violence 1 to 3 times in the last year 2013 (Sağlık-Sen 2013, 54). In addition to that, according to the 'white code' data sent to the Turkish Medical Association by the Ministry of Health, 46,361 health workers were exposed to physical and verbal violence among 2012-2017 (Cansu 2017). We are witnessing considerable amount of news about these violent incidents (Birgün 2019; Evrensel 2019; Medimagazin 2019).

However, according to current researches, it is also another fact that being a doctor has been a very prestigious status in Turkish society (Aydın et al. 2018, 91; Aydın et al. 2019, 109). In addition to that, medical faculties and in Turkey (including private faculties with %100 scholarship medical programs) are the schools that are receiving the highest-scoring students in student election exams. Whether having the ability to heal someone is a sacred positionality in societies for hundreds of years (Ulutaş 2011, 13), the current situation in Turkey shows a contrast scene for us. As an academic curiosity, the desire to investigate the theoretical basis of the change in the relationship between doctors and patients constitutes the research motivation of this thesis.

Research Limitations

Due to research methodology of the thesis, I did not encountered with any every-day life limitation. However, in terms of reaching the most contemporary, reliable, and official statistical indicators regarding the outcomes of the HTP was the only limitation, which I encountered for this thesis. In accordance with the research questions of this thesis, I aimed to reach data such as technological applications developed to empower patients regarding the results of the HTP and professional commitment and satisfaction of specialist physicians. However, TurkStat (Türkiye İstatistik Kurumu-TÜİK), the only official statistical data resource for Turkey, provides basic healthcare indicators only until 2017. Therefore, in order to provide reliable and latest data regarding the research questions of this study, I looked and compared to data, which is developed by the various international organizations, non-governmental organizations, and labor unions.

1.2.1. Transformation of Agency in Healthcare Policy

One of the two research questions of this thesis is how the HTP transforms the roles and relationships between patients and doctors. Germane to that, the healthcare system in Turkey has become more patient-centered as an outcome of the HTP. While the literature does not decisively distinguish stakeholders, as patients and the medical

specialists[1], of the healthcare policies in terms of analyzing the effects of the HTP, hereby a distinction is made between two stakeholders.

On the account of patients, this thesis differs from the other studies in the literature; it does not look at the neoliberal transformation of the right to health as a result of the interaction of welfare regimes with neoliberal policies, but it examines in the context of empowering patients with communication and technology practices. The HTP transformed the notion of being patient into 'customership'. Thus, patients as one of the two agency units of the healthcare system, are put forward as active dynamics of the neoliberal transformation of healthcare system in Turkey. By bringing the "patient empowerment" theory into the literature of healthcare policies in Turkey, I aimed to extend commodification discussions in the Turkish healthcare system.

Besides the complexity of medical knowledge, the expertise and societal status of objects that go beyond economic classes featured in the area of medicine. Both the occupational learning process and life experiences are making medical specialist as "true human experts" (Flyvbjerg 2001, 21). Their interwoven actions and decisions inhabit coherently flawing contextual dependent experiences and rule/knowledge-based phases. That is to say, their actions composed of both intuitions and cognition. However, transforming patients into customers affected the notion of healthcare and the occupational positionality of medical specialists. Their occupational autonomy is limited through the customer oriented healthcare policies introduced by the HTP. Discussing the impacts of the HTP on medical specialists with the "stewardship" theory enabled to comprehend shifting power relations between patients and medical specialists.

1.2.2. Transformation of Institutions in Healthcare Policies

Apart from political critiques and discourses, in a nutshell, the HTP is an institutional changing process. While the literature of contemporary healthcare politics contains several studies examining the bureaucratic demise of the healthcare system in Turkey, there is still a methodological lack of explaining how the JDP government and

[1] Studies, which are attempting to measure responses and reflections of healthcare workforce in Turkey, do not make a distinction among different branches such as practitioner doctors, medical specialists, nurses, and midwives (Seren 2014; Bıyık and Tekin 2015; Ağartan 2015). However, medical specialists are regarded as the subjects of the HTP throughout this thesis.

healthcare institutions had embarked upon the HTP. Although it is possible to take the easy way by explaining this transformation process as the initial consequence of neo-liberalism and impact of international organizations, herein this thesis, I problematized the institutional change and addressed the phenomenon of transformation in a discursive ground. Thus, the theory of "isomorphism" allowed me to discuss the HTP in a theoretical ground that whether the HTP is a genuine policy importation decided by main stakeholders or a policy instigation imposed by external actors.

1.3. Structure of the Thesis

Besides this first chapter of the thesis, which explains problem situation and methodology of the research, the thesis is conducted in four more chapters. Although this thesis aims to go beyond the classical theories which are approaching the healthcare policies from the welfare regime perspective, the second chapter, as the literature review, incorporated mainstream theories of welfare and social policy theory as well as the contemporary approaches to the transformation of the healthcare policies in contemporary Turkey.

In the third chapter of the thesis, the historical and current state of the healthcare system in Turkey is examined. The healthcare system of Turkey is analyzed as a public policy matter to indicate its main stakeholders. Therefore healthcare policymaking structure and the state of social security issues are also tackled in order to present a comprehensive state of the policy environment. At the end of this chapter, I made an analysis of the HTP in terms of its initiation process, background, and outcomes. Having illustrated the impacts of the HTP by means of statistical data, I went through the literature review in the third chapter.

In the fourth chapter of the thesis, I brought forward the patient empowerment, stewardship, and isomorphism theories in order to analyze the impacts of the HTP on agents and institutions of the healthcare policies. At the end of this chapter, an exemplifying case of Turkey's engagement with the EU in the context of healthcare policies is conducted. With this substantial case analysis I aimed to embody the new theories presented in the fourth chapter and demonstrate how the transformation in the Turkish healthcare policies justified by the JDP governments. In the fifth and the last

chapter, I presented my concluding remarks and suggestions for further researches on healthcare policies in contemporary Turkey.

2. LITERATURE REVIEW

In the contemporary scholarship, there is an extensive and diverse literature regarding “healthcare politics”. Each study focuses on different aspects of healthcare policies. Providing, coverage, expenditure, accessibility, and financing of healthcare services are some of the mainstream subject matters that are prevalently discussed in studies of healthcare politics. However, in the contemporary approaches towards the scholarship, it is seen that gender and migration aspects have also included/combined into the studies about healthcare politics (Bywaters and Mcleod 1996; Kuhlman and Anandale 2010; Aluttis et al. 2014, 1-7). Whereas, as an outcome literature review of the prominent studies published in the contemporary scholarship of healthcare politics, this section investigates the discussion regarding whether the healthcare is a commodity or right (Moran 2000, 135-160; Andersen 1996; Andersen 1990; Wendt 2009, 432-445). Due to the importance of welfare regimes for healthcare policies, this thesis also contains theoretical discussions to examine the relationship between welfare states and the notion of healthcare. According to the existing literature on welfare states and healthcare politics, debates regarding the capitalist economy and healthcare are piling around three premises. Firstly, studies which are seeing the development of public healthcare measures as a maintenance effort for labor health on behalf of capitalist development (Navarro et al. 2007, 27-69; Navarro 2007, 4; Marx 2017, 470). Second types of studies perceive healthcare services as tools for governing population (bio-politics) (Lemke 2015, 51-52; Ferlie et al. 2012, 341). Thirdly, explaining healthcare as an eventual development via negotiations, struggles, and institutional conflicts among labor force, capital, and state within the capitalist economy (Moran 1999, 29; Andersen 1990, 150-165; Gough 2001, 216- 221). Throughout this chapter these three approaches are addressed one by one. However, epistemologically, I adopted the third strand of the literature, which overlooks the notion of healthcare as an achievement of class based disputes.

2.1. Commodification, Welfare, and Healthcare

It is important to shed light on the question of whether health is commodified or not, in order to clearly determine the positionality of the arguments put forward by this thesis. In this context, we see that various positions have been formed in the literature. While in today's world, the concept of commodity encapsulates nearly all items of our everyday lives, primarily labor, capital, and land. However, a commodity in this thesis is regarded as Karl Polanyi defined and used to distinguish from fictitious commodities, which are "*objects produced to sale on the market*" (Polanyi 2001, 75). In this context, whether healthcare is attached to vast and various commodities via healthcare technologies, healthcare tourism, and pharmaceutical developments, as a notion of a science of curing sickness, its commodification or de-commodification has been a crucial question of welfare state theories. Because on one hand, technological devices and drugs can be seen as produced commodities to sell on the market, but on the other hand, science itself a service for public interest to improve articulated knowledge of health and environment of society (Irzık 2007, 137). In this sense, medical knowledge is not a proprietary/purchasable notion; rather, it is a knowledge-based on physicians' effort and time. By being a medical professional, doctors and nurses become stewards of medical knowledge (Pellegrino 1999, 251).

In this thesis, The HTP is perceived as one of the important milestones in the commodification of healthcare in Turkey. Attaining substantial commodification instruments such as technological devices or mediums of tourism lead medical specialists to over-professionalization and opened hospitals to build-operate-transfer contracts between public and private sectors. Nevertheless, after World War II, the Keynesian welfare state institutions enforced the notion of social rights, which means a temporary dissolution of commodification (Andersen 1990, 21).

The literature of healthcare politics and welfare has divided into both theoretical and ideological clusters. For instance, while Vicente Navarro represents the Marxist economic determinism in the literature, scholars such as Ian Gough, Gosta-Esping Andersen, and Michael Moran can be categorized as researchers promoting social-democratic welfare regimes through neo-Marxist or social-democratic interpretations.

2.1.1. Classical Approaches to Welfare State

Ian Gough claims that basic human needs corporate with the outcomes of the modern capitalist state mechanism (state intervention to handle class struggle); therefore, social policies such as healthcare, education, and retirement pensions have been underpinning the welfare state since the end of 19th century onward (Gough 1979, 64-68). Yet, Gough defines welfare state as "*a set of state policy outputs which pursue the goal of enhancing human welfare*" (Gough 2000, 182). Bahle, Kohl, and Wendt also prop this argument and introduces four phases evolving process of welfare states: Early formation (before World War I), institutional formation (interwar period until end of the World War II), golden age of welfare state until end of the 1980s, and the post-neoliberal era of reforming welfare state since the 1980s (Bahle, Kohl, and Wendt 2010, 572-573). However, Therborn annotates the state's role in welfare regime. According to Therborn, although Keynesian golden age represents working classes' process of gaining strength, the capitalist state's overall actions of producing social policies in welfare regimes aim to moderate between ruling class and working class (Therborn 1978, 169).

For Gosta Esping Andersen, who is one of the most cited scholars of welfare state literature, even though the strong establishment of the welfare state and social policies provides certain rights for working-class, the commodification of labor, as in terms of Polanyi's formulation, impoverishes workers (Andersen 1990, 36-37). Andersen perceives the welfare state as the institution of social stratification. In other words, Andersen argues that welfare regimes re-produces existing classes (Andersen 1990, 55). His categorization of welfare state regimes is one of the much referenced.

As it is seen in the 2.1, Andersen's categorization of welfare regimes basically based on the class struggle and states' intervention to these class struggles. While the liberal welfare states are tied to liberal ethics and contract based social security coverage, the corporatist welfare regimes envisage class positions more solid and grant social security rights upon those positions. In respect to social democratic welfare regimes, Andersen draws an ideal picture and puts equality of right to get healthcare at the center of the regime model.

Table 2.1. Welfare Regime Types in Gosta-Esping Andersen

Liberal Welfare State	Governed by the liberal work ethic and has a modest social assistance/insurance.
Corporatist Welfare State	Governed due to class positions, social insurance system covers only working individuals. Austria, Germany, France, and Italy are the countries nurtured corporatist welfare regime especially in the golden age of welfare state.
Social Democratic Welfare State	Rather than re-producing class struggle or uphold class status, it promotes equality of standards among citizens.

Source: Gosta Esping Andersen 1990, 27-28.

Related to the third kind of welfare regime classification of Andersen, Walter Korpi and Joakim Palme's model of comparison among welfare state regimes highlights the importance of institutions and coverage for welfare regimes to embrace different interest groups (Korpi and Palme 1998, 663-666). However, there are also studies, which are approaching healthcare from a right-based liberal perspective and making similar comments. For instance, Carsten Jensen claims that although the literature regards social rights as gaining from labor movements, according to Jensen, liberal right governments are also embracing and expanding social policies via bringing the notion of marketization into the healthcare policies (Jensen 2011, 909-912).

Michael Moran demonstrates the problem of welfare states in the post-neoliberal era. Moran emphasizes that the end of the "Bretton Woods" system and ever-mounting globalization has changed the conditions, which constituted the basis of welfare states. Therefore, for Moran, contemporary welfare states/regimes have the pain of changing. The golden age of welfare state expansion relied on the industrial production and consumption of the state. Hence, out of pocket payments by citizens and competitiveness among medical workers were not the issues introduced with the welfare state (Moran 2000, 141). Once, due to a revolution in medical technology and internationalization of labor market, doctors became prevalent actors in the allocation of healthcare resources. Yet, Moran carefully distinguishes professionalism from progress in the profession itself. Although being a doctor has become an influential profession, professionalism has become a "strategy to manage the labor market" between public and private sector (Moran 2000, 144).

Michael Moran introduces the four families of healthcare state. Moran considers healthcare more than a sub-policy field of welfare states (Ibid, 139). Due to the state's

relation to consumption, provision, and technology of healthcare, he classifies four types of healthcare states:

i.) ***Command and Control Healthcare States:*** Moran exemplifies Scandinavia and United Kingdom as command and control states. Accordingly, in both Scandinavian states and British National Health Service, the state has heavy command and control over the consumption (through income-based tax insurance system) of healthcare as well as provision of it. In this type of states, medical labor is usually employed by the state. However, the technology of medicine could be in the hands of the private sector (Ibid, 147).

ii.) ***Supply Healthcare States:*** The American healthcare system is the most significant example of these types of states. While out of pocket payments are constituting consumption side of the healthcare system, the occupational insurance system is a cornerstone of the competitive labor market. Provision and technology of healthcare is a major component of the market in these states (Ibid, 150).

iii.) ***Corporatist Healthcare States:*** The Bismarckian German system may be the source of this family. Public law institutions are embodying the healthcare system. According to Moran, due to law-oriented framework of the corporatist systems, they have not enough capability to adopt changings in healthcare technologies (Ibid, 152).

iv.) ***Insecure Healthcare States:*** This type of healthcare systems has formed in the post-neoliberal era. Portugal, Spain, Italy, and Greece, like the Mediterranean members of the EU, are apparent samples of the healthcare states. In these types of states, healthcare provision coverage is obviously not universal. Because they have not occurred in the golden age of welfare state, their institutional framework is vulnerable to fiscal fluctuations. Bureaucracy in these states is not well established as in the terms of Weberian terminology. They have chronic problems of nepotism, bribery, and political patronage (Ibid, 154).

Ian Gough categorizes healthcare state in Turkey within the regional Southern Europe. This categorization of Gough also contains Greece, Italy, Portugal, and Spain.

However, this categorization differs from Moran's and Andersen's through its methodology. When it is examined, social security is seen as a prominent evaluation criterion in the grouping of these six Mediterranean states. Hence, general assistance, group assistance, and tied assistance come forward as three sub-criteria to distinguish healthcare states from each other in Southern Europe. General assistance means cash benefits for all people, group assistance provides for only particular groups (such as pensions for elderly people), and tied assistance helps people to reach goods and services (Green Card application in Turkey) (Gough 2000, 134). Hereunder, Gough finds out a common pattern among these healthcare states. Accordingly, "none of these healthcare states has a comprehensive safety net, means-test is informal, and assistance benefits are low" (Moran 2000, 137-139).

2.1.2. Different Approaches to Welfare State

In addition to Andersen, Gough, and Moran's evaluations on the welfare and healthcare states, Charles F. Andrain adds different perspectives regarding the transformation of healthcare systems through neoliberal policies. While Andrain makes a similar comment to Andersen's critics over welfare states' problem of changing, he also draws attention to 'internationalization of national healthcare systems'. For Andrain, the EU's directives about drug production and pharmaceutical marketing constitute a major policy influence into its member states as well as into the peripheral countries (Andrain 1998, 4). While the contemporary literature on Turkey's healthcare policies recognizes influence of international organizations on Turkey's healthcare system, there is neither a source that covered the EU's impact on Turkish healthcare system nor a source that examines the mechanisms of transformation in a given policy are through external impacts. In this regard, the fourth chapter of this study scrutinizes the EU impact on Turkey's healthcare policies under the theoretical framework of isomorphic policy change.

Suchlike Andrain, Vicente Navarro demonstrates, from a Marxist perspective, how international financial institutions are affecting social reforms in developing countries. Navarro claims that international financial institutions such as the WB and International Monetary Fund (IMF) are stipulating/dictating neoliberal changes in countries' social policies as loan conditions (Armada, Muntaner, and Navarro 2001, 731).

Moreover, at the beginning of the 2000s, the EU's Maastricht criteria also conditions to limit public expenditure on social policy to ensure candidate countries' zero deficit in their national budget (Navarro 2001, 872).

2.2. Governance and Healthcare

Along with the 1970s' neo-liberal economy politics, healthcare has become the venue of broad interpretations and expectations. The Keynesian notion of healthcare right has started to be reframed. The authority of modern capitalist nation-states has been re-scaled. International financial institutions have become major actors in developing countries' inner state politics and public policy agendas. Healthcare as an inner social policy issue has become a reform flow and subjected to commodification processes. The concept of governance has been employed as a savior prescription for economic development. Studies, which are examining the contemporary meanings and functions of governance have also been imposed on ideological clustering analysis as same as in the welfare state literature. For this reason, defining the concept of governance is an elaborative necessity to understand the transformation of social policies in contemporary Turkey. Most of the international and supra-national organizations adopted this governance prescription within their meta-narrative of "globalization" and imposed to their peripheries (Goodin 2006, 27; Bayramoğlu 2014, 27-77).

Although the history of the concept of governance lays back to the 16th century (Gaudin 1998, 47), its modern promotion has started with the implementation of neo-liberal economics in the 1980s (Bayramoğlu 2014, 27). As well as the concept of politics, governance has also countless definitions. Etymologically, governance related with the word government, however, the root of the word comes from French and it means "The action or manner of governing a state, organization, etc." (Oxford Dictionaries 2018). The scientific definition of the word has been developed by both institutions and scholars.

WB has an important role in the promotion of the governance concept and understanding. Bank's 1989 report on the region of Sub-Saharan Africa, prescribed the notion of governance with the definition of "the exercise of political power to manage a nation's affairs". Deep inside this report, WB clarifies the definition of governance by attaching to the concept of governance more dimensions. The most featured of these

dimensions was including more stakeholders/intermediaries to the policymaking process (World Bank 1989, 60-61).

James N. Rosenau states that outcomes (such as protecting members of a political entity from conflicts, determining and operating policies, etc.) of governance are not different from government, however, the process of taking actions is in a broader frame (Rosenau 1992, 3). According to R.A.W Rhodes "governance refers to a new process of governing" (Rhodes 1996, 653). Gary Stoker underlines the baseline that every scholar or institution has agreed upon the definition of governance "as the blurred boundaries between and within public and private sectors" (Stoker 1998, 1).

Apart from definitions, it should be noted that governance is not a constant and single concept. There are different types of governance in the literature. As Jan Kooiman introduced us, for instance, there are global governance, corporate governance, and governance as self-organizing networks; new governance, etc. (Kooiman 1999, 68-69; Hill and Hupe 2002, 11-14). Guy Peters and John Pierre shows us in what ways is governance distinguished from the government. Accordingly, they state that governance as a way of governing society includes more agencies, more accountable, and transparent (Peters and Pierre 2008, 243-245). As we can see, governance resembles a shifting from the old model of governing a social or political entity, based on an inclusive paradigm.

2.3. Approaches to the Contemporary Healthcare Policies in Turkey

Among the studies that focus on Turkey's healthcare policies and social policies, I detected three contemporary approaches in the literature. On the first stance, there are studies that examining healthcare policies in contemporary period of Turkey (mainly starting from 2000s onwards) have an ideological or that is to say a strategical aim of foregrounding the HTP by significantly scrutinizing its positive impacts on Turkey's healthcare services (Bostan 2013, 102; Gürsoy 2015, 92; Stokes et al. 2015, 1-5). These studies mainly examines consumer (patient) / employee (healthcare workforce) satisfaction ratios, and private stakeholder analysis based on financial conditions and quantitative technological / infrastructural assets (Fevzi Akıncı et al. 2012, 24-25; Tatar et al. 2011). Articles and reports, which are written by institutions such as the WB, IMF, OECD, MoH, and researchers that are affiliated to these institutions present the neo-

liberal and governance-based transformation of Turkey's healthcare policies as an important progress "from laggard to leadership".[2] Scholars such as Kadir Gürsoy, Sedat Bostan, and Salih Mollahaliloğlu are focusing on the cost-containment effects and healthcare information technologies enhancement via the HTP. In addition, there are studies analyzing the changes in the social security systems and its outcomes (Yıldırım and Yıldırım 2011, 178-193; Atılgan 2016; Alper and Özgökçeler 2016).

The second group of studies, on the other hand, are approaching the transformation process from a more comprehensive and critical perspective. Although these studies also take the healthcare coverage, expenditure, quality measures, and patient satisfaction as determinants of transformation into consideration, they are also examining the outcomes and impacts of neoliberal transformation. In this context, three scholars in the literature are coming forward. Volkan Yılmaz in his book *The Politics of Healthcare Reform in Turkey* analyzes the transformation of healthcare policies from different theoretical perspectives and stakeholders. While studies in the first group generally use the same and simple quantitative data sets, Yılmaz in mixing qualitative and quantitative research methods and puts forward fresh data about impacts Turkey's vanishing state of welfare. He includes different policymaking actors in his research. Apart from the government and bureaucratic institutions, Yılmaz sheds light on the role of the WB in the transformation of Turkey's healthcare policies and he questions the reflections from competing policymaking actors such as Turkish Medical Association, unions, and Non-Governmental Organizations.

Tuba Ağartan and Tim Dorlach are the other featured researchers on the critical side of the literature. While Ağartan's papers vary from marketization debates to state of health professionals, Dorlach investigates detrimental relationships between neoliberal capitalism and Turkey's social policies. According to Ağartan, the HTP's universal healthcare coverage (health for all motivation) aim and it's market-oriented policy tools are two contradictory elements in the transformation process of Turkish healthcare politics (Ağartan 2012, 458). In her other paper, she claims that the HTP is banalizing healthcare professionals, although they (doctors) must be the key stakeholders of the

[2] World Bank's attention and desire to transform Turkey's healthcare policies started with the election of the Justice and Development Party government in 2002 and followed with a deep association through big amount of loans. Therefore, it can be concluded that the marketization and internationalization process of Turkey's healthcare services has initiated with WB's reports (World Bank 2003; Akdağ 2007; Akdağ 2009; Barış et al. 2011, 579-582; Bump et al. 2014, 2-3; Bump and Sparkles 2014, 15-24; OECD 2014) .

healthcare policymaking process. In addition to that, for Agartan, the notion of competitiveness is introduced by the HTP, therefore, the workload of the healthcare professionals has increased while their role and authority have been decreasing (Ağartan 2015, 1624).

Tim Dorlach proposes the conceptualization of social neoliberalism to understand the neo-liberal transformation during the JDP government. According to Dorlach, this way of transformation of the JDP government appears like caring about the poverty problem in the society. However, it produces solutions to this problem by elasticizing labor markets (Dorlach 2015, 524). From this perspective, in another study, he claims that the JDP's neo-liberal policies have been compromised by its conservative ideology. In this study, he examines the pharmaceutical policies of the JDP government in 2009. He finds out that beginning from 2000s JDP's pharmaceutical policies were "business-friendly" yet, in 2009, with a reform, these policies turned into anti-liberal regulations (Dorlach 2016, 58-59).[3] Thus, Dorlach illustrates how a strong political center (government) shapes policy environments around itself regarding or disregarding different interest groups.

Apart from these studies, there are studies that examine the impacts of neo-liberal transformations on to citizenship status and social rights. Ata Soyer's book about the history of healthcare politics in Turkey is one of the works that has been referenced in various studies and researches. Soyer presents us the long trajectory of modern Turkey's public healthcare policies from its very establishment to the JDP government (Soyer 2004).[4] Another scholar, Seyhan Erdoğdu demonstrates us the background of social security reforms, which is an important part of the HTP, of the Justice and Development Party government. Erdoğdu illustrates the pressures and interventions of international financial organizations into the reform packages (Erdoğdu 2009, 660-689). Selçuk Atalay examines the "public-private partnership" aspect of the neo-liberal governance within

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[3] Barış Alp Özden also gives thoughts about the same paradigm. Özden claims and scrutinizes the successful overlapping at the Justice and Development Party's populist and neo-liberal policies in the context of welfare regime discussions. According to Özden Turkey's traditional welfare *regime [stemming from late Ottoman Period (Özbek 2008, 42-60)]* is also corresponding with the Justice and Development Party's welfare policies. The Justice and Development government empowered pro-government Non-Governmental Organizations and charity foundations to sustain social "aids" (not rights), while it was elasticizing the labour markets, payments, and working conditions (Özden 2018, 236).

[4] Although Soyer's study is one of the most referenced ones on Turkey's healthcare policies, due to my own examination it also has the problem of ideological bias. Therefore, as an additional source for the history of healthcare politics in Turkey, Aytul Kasapoğlu's article would be beneficial (Kasapoğlu 2016, 131-174).

healthcare politics. Atalay shows us the fact that whether the HTP aimed at a solid decrease in public expenditures for public healthcare services, building huge health campuses and city hospitals attests us the total opposite in the current financial situation (Atalay 2015, 57-85). Egemen Cevahir conducts research about the initial impacts of the HTP and neo-liberal governance on primary healthcare services' professionals in contemporary Turkey. Due to his findings, he concludes that the current transformation in healthcare policies has decayed the status of healthcare professionals and on the other hand, it has transformed patients into customers (Cevahir 2016, 289).

The third flow in the literature consists of studies, which are encompassing the issues related to healthcare workforce in healthcare politics. Under the influence of the governance and with the perception that the HTP is advance progress in the healthcare policies of Turkey, studies written in this flow of literature are regarding healthcare professionals as a whole group of 'passive actors'. In this context, researches conducted among healthcare professionals are focusing on the issue of motivation and satisfaction ratios primarily regarding the health reform in developing countries (Franco et al. 2002, 1255-1266; Fritzen 2007). Lynne Miller Franco and her associates find out the theoretical basis of worker motivation determinants for healthcare reforms. In their study, all the workers in the healthcare "sector" are assumed as actors who must comply with the reforms. In the Mischa Willis Shattuck and her collages' paper, they evaluate the outcomes of researches about healthcare worker motivations due to healthcare reforms (Shattuck 2008).

There are also studies, which are embracing the workforce aspect of the transformation in the healthcare policies due to tentative effects of the neo-liberal governance in contemporary politics. Çağla Ünlütürk Ulutaş, in her book, examines the 'proletarianization' debates among healthcare professionals, in particular, doctors. According to Ulutaş, the essential (because of the ability to heal someone) status of being a healthcare professional (doctors, nurses, midwives) has shifted into regular proletarian locus due to regulative impacts of neoliberal transformation of healthcare politics in Turkey. Ayhan Görmüş, on the other hand, dives into the decentralization and marketization arguments within the performance-based payment system and contractual employment regulations of the HTP (Ulutaş 2011).

3. TRANSFORMATION OF HEALTHCARE POLICIES IN TURKEY

The health policy or commonly used healthcare policy refers to "*decisions, plans, and actions that are undertaken to achieve specific health care goals within a society"* (WHO 2018, "Health Policies"). National health policies have the vital role of ensuring the health of a state's population. Constituting and maintaining a national health policy is a very "*complex and dynamic process*" (WHO 2018, "National Health Policies). To this extent, healthcare policies are open to change and participation from different kinds of stakeholders. Healthcare policy structure in the modern Republic of Turkey has started by the establishment of a separate Ministry of Health (MoH) in 1920.[5] Just after WWI, the Ministry has the responsibility of preventing endemic diseases such as malaria, tuberculosis, and syphilis (Ağartan 2005, 4).

3.2. History of Healthcare System in Turkey

After World War II, the Keynesian economic policies had become widespread and health of population had become a major issue for nation-states. Therefore, the notion of welfare state notion had established especially in Western states (Jessop 2002, 61; Cevahir 2016, 30-34). However, Turkey as one of them had initiated its dubious healthcare system by the establishment of the Social Insurance Institution (SII) (generally known as Sosyal Sigortalar Kurumu / SSK). By then laborers had started to be covered under a sort of health insurance, yet, poor people from rural areas were still under no

[5] There were also pre-implications of modern welfare institution at the late ottoman period. Nadir Ozbek has important studies about this issue. However, he claims that applications during the late Otttoman period were at the extent of charity and paternalist politics rather than a social policy or so (Özbek 2008, 42-62).

health protection (Kohşwes 2014, 36). SII established its own hospitals. In the following 15 years, responsibilities and realm of the jurisdiction of the MoH had widened. For instance, the ministry started to establish different kind of healthcare institutions for children and mothers and re-placed health workforce from urban areas to rural areas (Ağartan 2008, 9).

In the post-1960 coup period until the 1980s, most of the public policies and institutions re-defined by the 1961 constitution. A new economic model, "import substitution industrialization", had adopted. The standard and availability of healthcare services became a major issue for healthcare policies. State Planning Organization (STO) established, therefore the population planning had also become another major issue for the state (Bayar 1996, 777). The Law on the Nationalization of the Healthcare Delivery (Law Number 224) had enforced in 1961 (Resmi Gazete 1961). This law had brought the notion of socialization in healthcare services to the agenda of healthcare policymakers. According to the law, healthcare services should be delivered equally and continuously. The law also projected an integration for public healthcare services as preventive and environmental health services. In the "first five-year development plan", prepared by STO, numbers of important policy changings were introduced, suggested and met in the context of healthcare policies. For instance, planning public healthcare services through the MoH, encouraging the establishment of private hospitals, and the establishment of universal health insurance, etc. (Ağartan 2008, 4; Tatar et al. 2011, 18; Devlet Planlama Teşkilatı 1963, 37&67&110). A few of them had met but some of those policy changings not met with the goals. For example, the establishment of a universal insurance system goal of the plan had not met until the HTP enforced it. Up to the 2000s, the insurance system was multipartite: SII, State Retirement Fund (EMEKLİ SANDIĞI), Social security organization for artisans and the self-employed (usually known as BAĞ-KUR).

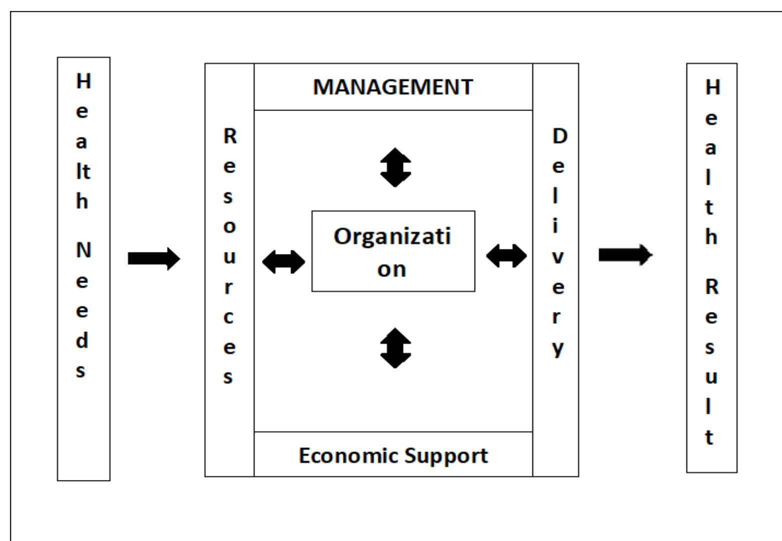
The 1980 coup had changed the mindset of the state institutions. The "import substitution industrialization" understanding had left. Turkey started to adopt neo-liberal economy policies with well-known January 1980 decisions of the coup government (Öniş 2010, 48). Statutory decrees by the post-coup government had enacted radical changes in healthcare policy. For instance, providing first, second and third step healthcare services had redesigned. Hereunder, first step healthcare services provided by MoH tied to community health centers, mother-child-family planning centers, tuberculosis dispensaries; second and third healthcare services provided by other state institutions, foundations, associations, and MoH (Kasapoğlu 2016, 142). In 1987, the government

tried to establish general health insurance but it failed. In the 1990s, parallel to the sixth development plan, privatization of public health institutions had started. Besides, by the suggestions of the WHO, the government had adopted regional health directorates, which is also suited to the concept of governance. Local health authorities such as "provincial directorate of health" established for the first time in this period. In 1992, the "green card" insurance system policy for poor citizens had enacted (Kohlwes 2014, 46).

3.1.1. Institutions of Healthcare Policy-Making in Turkey

In the most classical form of making public policy, *"the stages theory*" introduced by Harold Laswell in 1956, proposes that a public policy process should be considered under five to seven stages such as agenda-setting, policy formulation, policy legitimization, policy implementation, and evaluation. Other important scholars of public policy such as James E. Anderson, Garry D. Brewer, and Peter De Leon also follow this pathway and contribute this theory by explaining and adding different stages of the policy cycle (Jann and Wegrich 2007, 43; Anderson 2011, 23). Milton Irwing Roemer's model of the national health system model and relations among the system apparatus or in other words the general theory of healthcare policymaking black box also overlaps with the WHO's design of healthcare components and stages theory of public policies (Kleckowski, Roemer, and Werff 1984, 15-16).

Figure 3.1. National Health System Model / Black Box



Source: Irwing, 1991.

As it seen in figure 3.1, this very abstract model of black-box sums up the policymaking groups and processes Firstly. health policy demands comes from “needs” and enters/puts into the black box circulation, which is composed of resources such as workforce, facilities, intelligence, health supplies, certain kind of budget (not just money) and expertise/authority of management actors. Therefore, healthcare policies come out as various healthcare delivery services. The black box process/policy cycle concludes with the results/responses to the determined, formulated, and implemented policy. When I tried to apply this model to the Turkish healthcare policymaking system, I came across various actors, which are at the different points of the black box.

- **Constitution**

According to the Turkish Constitution (1982):

> “Everyone has the right to live in a healthy and balanced environment. …The State shall regulate central planning and functioning of the health services to ensure that everyone leads a healthy life physically and mentally, and provide cooperation by saving and increasing productivity in human and material resources. The State shall fulfill this task by utilizing and supervising the health and social assistance institutions, in both the public and private sectors. In order to establish widespread health services, general health insurance may be introduced by law” (Article 56 2019, 27).

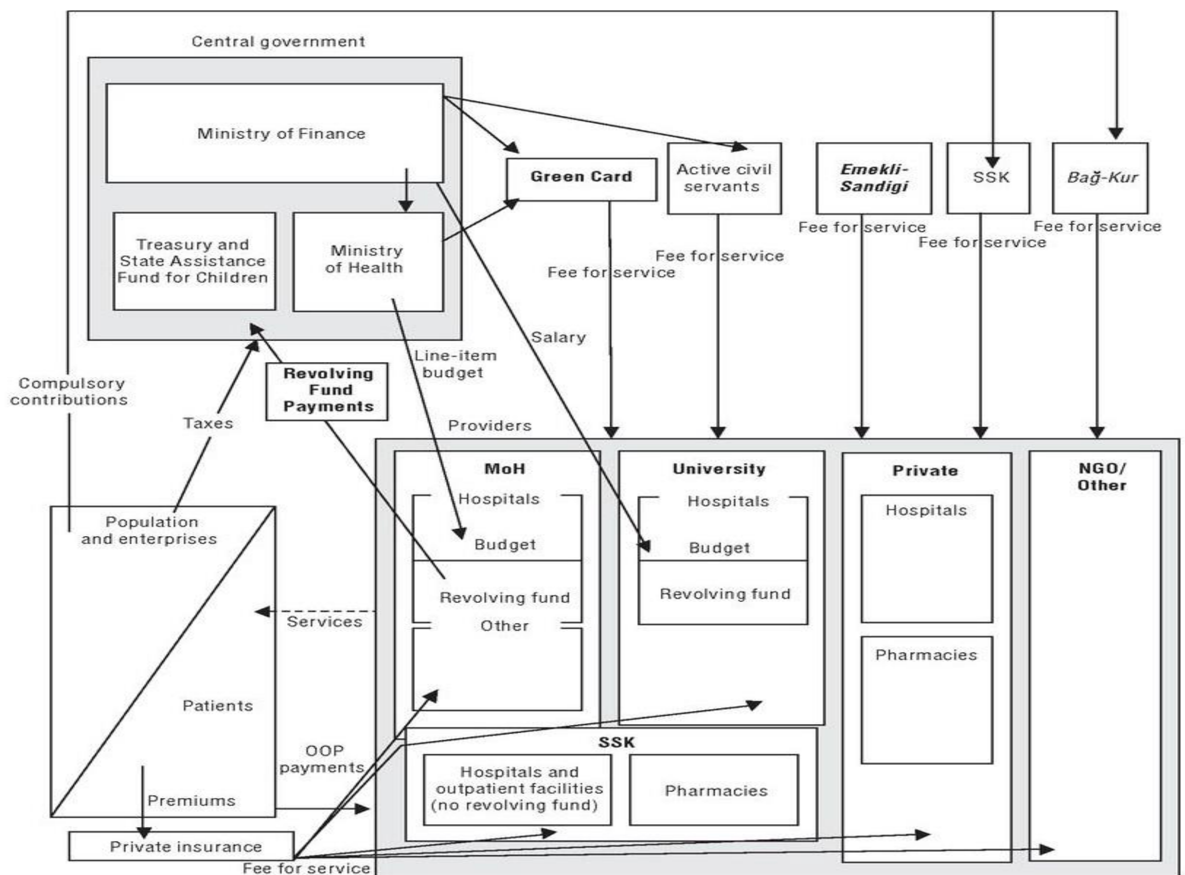
What is interesting about the formulation of healthcare in the 1982 constitution is that the constitution does not make any classification regarding the possession of right of healthcare by citizenship or non-citizenship. In this sense, it fits into the Andersen’s social democratic welfare regime definition. On the other hand, it emphasizes the role of healthcare in the productivity of humans and presents itself as the operative force of the black box.

In this context, we can claim that policymaking institutions are also the main components of the healthcare policy environment in Turkey. Up to 2003, there were too many and different institutions in the policymaking cycle. To be able to analyze the contemporary situation in Turkey, in Figure 3.2, see the complex institutional ties up to 2003. At the top of the policymaking structure is the central government as it is stated in the 1982 constitution. However, until the initiation of the HTP, the financial structures are intertwined with the healthcare service delivery institutions.

As it is seen in Figure 3.2, prior to the initiation of the transformation of healthcare policies with the HTP, there were five types of insurance systems, SII, Retirement Fund for Civil Servants (Emekli Sandığı), Retirement Fund for Artisans and Self-Employed (Bağ-Kur), and private insurances. Moreover, in the 1990s the Green Card coverage was enforced to provide healthcare services to poor citizens. Finance of the healthcare expenditures and policymaking bodies of fiscal and budgetary issues of healthcare policies are composed of different institutions such as Ministry of Finance, MoH, university hospitals, local governments, special state agencies, direct citizen contributions by wage-cut insurance payments, private spending on different medical and pharmaceutical operations/medicines, etc.

Delivery of the healthcare services was also very complex and separated. University hospitals, Private hospitals, SII hospitals, State hospitals, Army hospitals, Non-Governmental Organizations, and other sorts of healthcare centers were co-existed in the same healthcare environment but for different types of citizens. This situation was also against the universal coverage norm of the WHO at those times (Gürsoy 2015, 87; Görmüş 2013, 139). After the initiation of the HTP official healthcare policymaking institutions (state and private healthcare services providers, external policymaking actors, healthcare employees, and citizens) have had a more simplistic as well as the unequal relationship in contemporary Turkey. In other words, even though the financial institutions are amalgamated an separated from the healthcare service delivery institutions, current relationships among other stakeholders has become more complex and uneven.

Figure 3.2. Turkey's Healthcare Policymaking Institutions up to 2003



Source: OECD 2008, 29.

- **Health, Family, Work, and Social Issues Commission in the Turkish Grand National Assembly**

Health, Family, Work, and Social Issues Commission is one of the main healthcare policymakers. Its main duty is preparing and proposing new laws or proposing law amendments about healthcare policies. The commission composed of parliamentarians from different political parties. Currently it is composed of 13 JDP, 6 Republican Peoples' Party, 3 People's Democratic Party, 2 Nationalist Movement Party, and 2 İyi Party members. In other words, this is the main body of legislating healthcare policies (TBMM 2018). Apart from this commission, the Turkish Grand National Assembly as a legislative body is also very important for the entire healthcare policymaking environment. MoH's budget and internal policy demands are discussed in this main body.

- **Ministry of Health**

In 2011, after the adoption of Statutory Decree 663 the Ministry of Health has had more effective and central role on the policymaking of healthcare services. However, the centralization of healthcare policies under the MoH has started with the initiation of the HTP. For instance, in 2005, SII hospitals have transferred to the ministry. In 2016, military hospitals transferred to the body of the ministry. Besides, the Ministry is also responsible for appointing, shifting, and eliminating medical workforce in the public health centers. MoH is also containing several regional and central directorates. Every city has a provincial directorate of health (İl Sağlık Müdürlüğü). The provincial organization of the Ministry is very detailed and complex. From family health centers, dispensaries, health houses, public health centers to laboratories, there are too many policy implementations, service-providing facilities, management, and healthcare resources are under the responsibility of MoH. Other important MoH-related policymaking institutions listed below:

a. Health Policy Committee
b. Directorate-General for Health Services
c. Directorate-General for Health Researches (Resmi Gazete 2011, Decree No. 663).

- **Turkish Medical Association (TMA-Türk Tabipler Birliği)**

TMA was established in 1953. Turkish Medical Association’s main purpose is to protect, promote, and improve public health for everyone in Turkey, to protect the morals of the medical profession, and to protect the rights of medical professions. TMA has representative units in every public hospital, additional TMA has several regional/ local chambers and committees to evaluate healthcare policy outputs. The official institutions, laws, decrees, and regulations also recognize the TMA (TTB 2018).

Although the healthcare policy formulation, legalization, and implementation depends on the formal/official institutions, there are so many medical Non-Governmental Organizations and associations, which are taking place in the healthcare policy environment. For instance, Positive Living Association (Pozitif Yaşam Derneği), is one of them. In 2003, a group of patient and doctors established this association for fighting

against AIDS disease (Pozitif Yaşam 2018). Another and the most known medical foundation in Turkey called LÖSEV (Foundation for Children with Leukemia) has established in 1998 and take the responsibility of curative services from SII hospitals (LÖSEV 2018). Apart from foundations and associations, medical work force unions and national media organs are important actors/players for discussions and cultivations of healthcare policy demands (Gezen 2015, 177).

- **External Actors**

There are three important actors in the healthcare policy environment: WHO, WB, and the EU. WHO's actions and stipulations under the general policy framework of "health for all" sets standards for most of the countries on the World. Notions such as universal coverage, equal accessibility for healthcare services, environmental health, and preventive healthcare policies are coming from the normative power of the WHO.

WB as another external player is important for the policy evaluations, assessments, and data collections about healthcare policies of Turkey. Indeed, the role of the WB is more affectional in the context of contemporary healthcare policies in Turkey. The WB has been lending money within the scope of different healthcare policy changing projects. Indeed, Turkey has still ongoing money transactions from the WB. The WB gave 60 million Dollars in 2004 for the "Health Transition Project" and 75 million Dollars between the years of 2009-2015 for "Project in Support of Restructuring of Health Sector". Currently the WB has been lending 134 million Dollars for the "Health System Strengthening and Support Project" since 2015 (World Bank 2018, "Health Transformation Program and Beyond").

EU's standards and stipulations for Turkey is one of the main motivations for Turkey's initiation of the HTP as a healthcare policy. Moreover, these all three organizations are the main exporters of the concept of governance (Kickbush and Gleicher 2012, 35&41&81). Apart from their institutional and functional importance, as it will be presented in the following chapter, the HTP's outcomes and impacts on Turkish healthcare policies are actually dependent to these international organizations.

3.3. The Health Transformation Program (HTP)

In January 2003, the 58th government declared an “Emergency Action Plan”. Therefore, it placed the HTP under the “Social Policy Transformation” issue (Justice and Development Party 2003, 88-89). According to Tuba Ağartan, the HTP constructed by a top-down attitude, therefore, all the transformation process was located under the Ministry of Health. Even though all the Emergency Action Plan was proposing a “participative approach” to public policies to import governance into Turkey’s agenda, the HTP had sui-generis characteristics as a policy reform. Instead of internal stakeholders, the HTP has operated hand in hand with external policy actors (Ağartan 2012, 463). Likewise, Volkan Yılmaz claims that reform in the healthcare policies of Turkey was also an election campaign slogan for the JDP. Because of this reason, there is a strong “ownership” notion in the coding of the discourse of the HTP, which is also related to the election success of the JDP (Yılmaz 2017, 56).

The basis of the discourse created by the JDP in the context of the necessity and ownership of the HTP can be examined by looking at health indicators and social discomfort from the 1970s to the early 2000s. As it is seen in the Table 3.1, despite the enhancement of technology and science over the years, there is a stagnation of ratios. While population growth ratios are decreasing significantly from 2.50 in 1970 in to 1.62 in 1999, the total fertility rates are also showing a decrease nearly %50 from 1970s to 1999. In this regard, these indicators consisted the justification ground for the initiation of the HTP.

For instance, in the MoH’s 2008 and 2012 progress reports on the HTP, after a long introduction regarding the history of healthcare policies in Turkey, it is clearly indicated that the HTP initiated to increase standards of basic indicators of healthcare, satisfaction ratios, and financial effectiveness (Akdağ 2008, 26; 2012, 51). Moreover, a similar argumentation had also used in the OECD evaluation report on Turkey’s healthcare system in 2008. In this report the aim of the HTP is formulated as making healthcare system more affective through ameliorating financial sustainability, governance, effectiveness, and user satisfaction states in the healthcare policies (OECD 2008, 36; OECD 2019).

Table 3.1. Basic Health Indicators (1970-1999)

	Annual Population Growth (%)	Crude Birth Rate (per-100 population)	Crude Death Rate (per-100 population)	Infant Mortality (per-100 live births)	Total Fertility Rate	Life Expectancy At Birth (years)
1970-1974	2.50	34.5	11.6	140.40	4.46	57.9
1975-1979	2.06	32.2	10.0	110.79	4.33	61.2
1980-1984	2.49	30.8	9.0	82.96	4.05	63.0
1985-1989	2.17	29.9	7.8	65.22	3.76	65.6
1990-1994	1.85	23.5	6.7	50.56	2.80	67.3
1994-1999	1.62	21.4	6.5	39.02	2.45	68.6

Source: B. Serdar Savaş, Ömer Karahan, R. Ömer Saka eds. 2002, 14.

As another indicator, public healthcare expenditure in 1997 was around 47 Million Turkish Liras, and %49 percent of this amount spent on primary and curative healthcare services (Tokat 2001, 6). However, as it is seen in Table 3.2, the main cause of death infants were infectious diseases in the same year.

Table 3.2. Causes of Death by Age (1997)

Age	Cause
0-12 Months	Infectious and perinatal diseases
1-5 Years	Infectious diseases and complications typically associated with Malnutrition

Source: Zafer Öztek et al 2001, 14.

In addition, the patient satisfaction rate, which was one of the main justification argument for the initiation of the HTP, was 41 % in 2003 (Sasam Enstitüsü 2017, 17). These rates and indications were foregrounding the social unrest discourse of the JDP,

which can also be observed from various media channels in the late 1990s (Youtube 2018; Çelebi 2001).

To enforce the HTP, the Government amended a set of laws and regulations. To unify all insurance system under Social Security Institution (Sosyal Güvenlik Kurumu / SGK-SSI), Administrative Unification of the Social Security System Act in 2006 (Act No. 5502) and the Social Security and Universal Health Insurance Act in 2008 (Act No. 5510) has proposed by the government and amended by the Turkish Grand National Assembly. Scope and context of the Green Card application also expanded, however, still informal workers are out of the application, which means, the healthcare system of Turkey is still away from the notion of universal coverage. According to the Emergency Action Plan's first draft, the HTP was aiming to reach regulations listed below in a one year term:

- Ministry of Health will re-structured
- The differentiation among public hospitals, institution hospitals, and SSK hospitals will be erased; therefore, all the hospitals will be gathered under a single roof.
- Healthcare service providing and financial issues will be separated
- A 'general health insurance' system will be established
- Family practicing centers will be opened (Justice and Develeopment Party 2003, 99-100; World Bank 2003, 43&73-77).

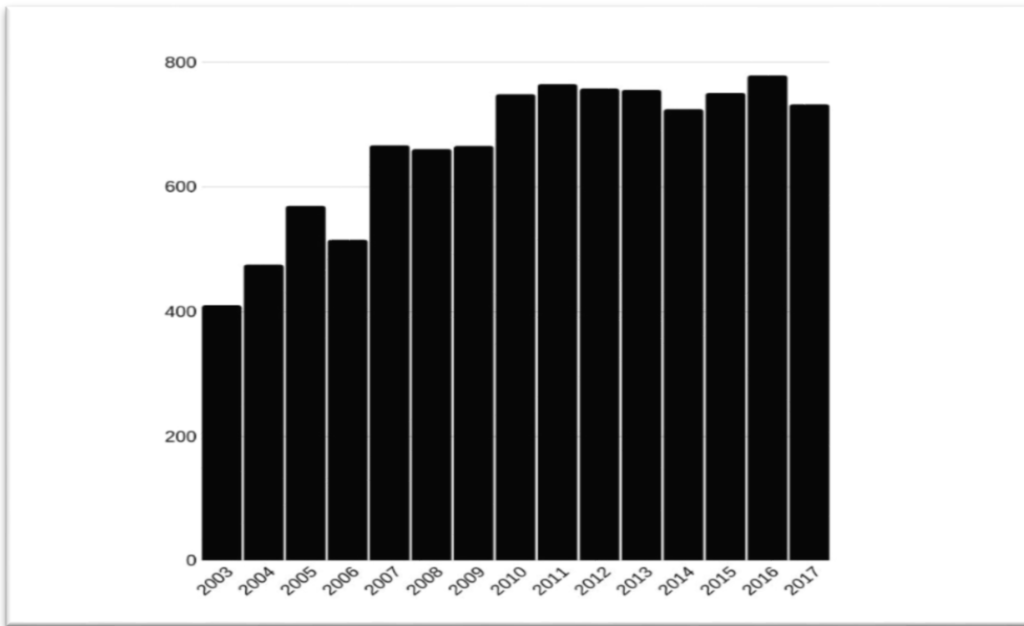
Besides these actions, according to Agartan, the new Social Security Insurance system allowed co-payments in private healthcare facilities; therefore, numbers of private hospitals have raised from 270 in 2002 to 365 in 2007 (Ağartan 2015, 1625). In 2016, the number of private hospitals increased to 549 (rapor.saglik.gov.tr 2019). In accordance with the new reform policy measures, the HTP introduced competition concept with the healthcare workforce. Alongside that, the neo-liberal Public-Private-Partnership model was adopted in building new public healthcare facilities, hence, private service providers also integrated to public facilities.

With Public-Private-Partnership or Build-Lease-Transfer models, the MoH has been constructing large-scale healthcare facility campuses, called "city hospitals" (sygm.saglik.gov.tr 2019). Although Public-Private-Partnership models have used to construct energy-producing facilities, in 2005, by amended the Law No. 5396, the JDP government added the MoH in the scope of Public-Private-Partnership. Thereafter, the Ministry of Health has established a department particular to Public-Private-Partnership

projects. As stated in the section of external actors of healthcare policies, the WB had also crucial impact on the promotion of these public-private-partnership projects. The WB lent 5.5 million Euros for enhancing capacity of public-private-partnership projects under the framework of “Project in Support of Restructuring of Health Sector” between the years of 2009-2015 (World Bank 2016, 4). Moreover, these loans have been continuing with the ongoing “Health System Strengthening and Support Project” since 2015. The WB planned to send 13.56 million more Euros equivalent to technical support to public-private-partnership projects (World Bank 2015, 48). New payment systems based on performance such as “Diagnosis-Related-Groups” enforced (Mathauer and Wittenbecher 2013, 751).

According to Turkey’s official statistics, institutional data, citizen satisfaction level for healthcare services has risen %39 in 2003 to %72 in 2017. It seems that, from the patient perspective, one of the aim of the HTP, which was rising user satisfaction levels, is achieved by the HTP. However, according to Agartan’s study, the HTP significantly increased the workload of healthcare professionals (Ağartan 2015, 1624). OECD evaluations also support her claims. According to OECD healthcare quality report of 2014, even though the number of healthcare professionals has risen throughout HTP, per capita payment system in primary healthcare services causes a ratio of 3.500-4.000 patients to per doctor (OECD 2014, 28). According to the Turkey Union of Public Employees in Health and Social Services, in 2018, there are 5635 patients per 1 doctor and 100.000 patients per 99 medical specialists (turksagliksen.org.tr 2019). Another research demonstrated that in 2003 there were 1372 patients per 1 doctor (Ergüç 2014, 5).

Figure 3.3. Patient Satisfaction Ratios



Source: TurkStat 2019.

One of the most important aims of the HTP was lowering the healthcare expenditures and costs to Gross Domestic Product. However, according to Yılmaz, the share of public health expenditures rose from 3.7 in 2003 to 4.6 in 2013 (Yılmaz 2017, 9). Ratios and numbers are varying among institutions and scholars. For this reason, I wanted to compare Yılmaz's findings with TurkStat's. However, TurkStat's research shows (see in Figure 3.3) only the ratio of public and private healthcare expenditures together related to Gross Domestic Product.

Figure 3.4. Healthcare Expenditure (1999-2018)

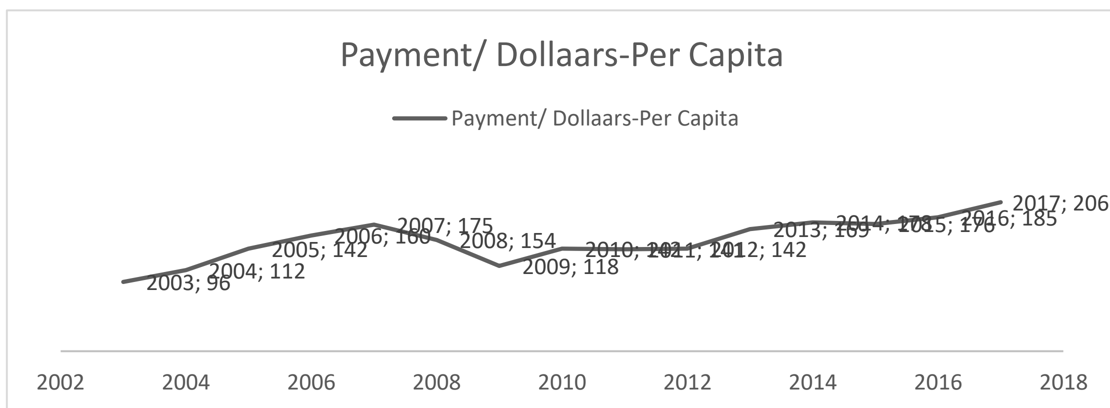
Indicators on health expenditures, 1999-2018

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total health expenditure (Million TL)	4 985	8 248	12 396	18 774	24 279	30 021	35 359	44 069	50 904	57 740	57 911	61 678	68 607	74 189	84 390	94 750	104 568	119 756	140 647	165 234
Proportion of total health expenditure to gross domestic product (%)	4,7	4,8	5,1	5,2	5,2	5,2	5,2	5,6	5,8	5,8	5,8	5,3	4,9	4,7	4,7	4,6	4,5	4,6	4,5	4,4

Source: TurkStat "Health Expenditure Research" 2019.

As it is estimated in the figure 3.4, the share of the health expenditures related to Gross Domestic Product decreased from %5.2 in 2003 to %4.5 in 2017. Although the HTP ambitiously aimed to decrease public healthcare expenditures, the decrease is only %0.7. However, according to OECD data (see figure 1.2.2.3), out of pocket expenditures increased from 96 Dollars per capita in 2003 to 206 Dollars per capita in 2017.

Figure 3.5. Out of Pocket Expenditure on Healthcare



Source: OECD “Data on Health Spending” 2019.

As it is discussed briefly above the HTP is a neoliberal project that has been carried out by the JDP governments mainly in order to commercialization of the healthcare system of Turkey. The goals and practices set out throughout this program have eliminated a rights-based understanding of the health care system, resulting in a patient / customer-oriented system. Out-of-pocket health expenditures increased by 214% and the number of patients per doctor increased by 410%. Since 2013, when the HTP was officially concluded, there have been more than 40,000 cases of health violence. These data, in addition to a quality-oriented health understanding and basic health indicators, reveal that there are important problems in today's healthcare policies.

4. CONTEMPORARY THEORIES AND TURKISH HEALTHCARE POLICIES

It is a fact that healthcare literature depends upon either class-based studies or human capital researches. However, to this thesis, it is important to discuss another aspect of the literature by going beyond the economy politics to newly established power relations due to the HTP. In Turkey, transformation of healthcare information technologies is also an impact of governance over healthcare policies. The role, responsibility, and power of patients in the medical examination processes have been increased. In addition to that, diversification (new private medical schools) of medical education has also increased for years during the JDP governments. For instance, while the student quota of medical faculties of private universities was 205 in 2003, this number increased to more than 10 times in 2018 and reached 2186 (Hekim Postası 2018). According to the privatization in medical schools (including healthcare high schools) lead to the decline of the quality of healthcare education. Therefore, the status of healthcare professionals is disenchanted in the eyes of "patients". From this perspective, I would like to bring the discussions about the empowerment of patients and decay of medical habitus, which is an undiscovered study field within the 'Foucaldian' theoretical studies. Even tough in the contemporary literature of Turkish healthcare politics does not include or inter-relate the theory of patient empowerment into its scope, it can be seen that the literature of the European healthcare politics and policies has a contemporary focus on this theory (Piper 2010, 173-177; Juritzen et al. 2013, 443-455; Rensburg et al. 2016, 1-11; Collyer 2018, 121-126).

4.1. Patient Empowerment and e-Heath

Although the improvement of health information system has been a 20-years history of the issue[6], the development of health information technologies was one of the most launched aspects of the HTP (Akdağ 2009, 95). Therefore, it can be argued that the steps taken in this context also contribute to patient empowerment or patient-centered healthcare understanding (Saluvan 2015, 99). According to Jorge Calvillo, Isabel Roman, and Laura M. Roa, "*Patient empowerment is an initiative that aims to make patients take care of their own health status*" (Calvillo, Roman, and Roa 2013, 644) However, The HTP's discourse on the importance of health information technologies (Akıncı et al. 2012, 22) on behalf of improving healthcare quality standard (Mollahaliloğlu et al. 2011, 84-84; WHO 2012; Akdağ 2015, 3) has transformed healthcare system into a market-oriented neoliberal policy area (Renedo and Marston 2015, 3). In other words, empowering patients as an agency through information technologies has changed the power relations among patients, doctors, and institutions (Anjoulat, dHoore, and Deccache 2007, 16-17). The autonomy of health professionals decreased via extending the autonomy of medical information "field" to patients (Collyer 2018, 119).

Both the WHO and the EU have been prioritizing the establishment of enhanced healthcare information systems such as "e-health" since the beginning of the 2000s (European Commission 2003, 46; WHO 2016, 11). E-health or "health information systems" stands for using the internet and computer-based information systems to provide healthcare services and health-related information to "consumers"/patients (Eysenbach 2001). WHO has been defining the e-health concept as "*the cost-effective and secure use of information communication technologies (ICT) in support of health and health-related fields, including health-care services, health surveillance, health literature, and health education, knowledge and research*" (WHO 2016, 11) since 2005. Based on this definition, the EU's understanding of using information systems in healthcare services means *"an integrated effort to collect, process, analyse, report, communicate and use comparable health information and knowledge covering all Member States to understand the dynamics of the health of EU citizens and populations in order to support policy and decisionmaking, program action, individual and public health outcomes, health system functioning, outputs and research in the EU"* (Bogaert and Oyen 2017, 2). E-health or enhanced usage of information systems in healthcare deliverance has been a distinctive

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[6] The healthcare information systems establishment have started in 1992 with a project funded by World Bank. The General Directorate of Health Information Systems established in 1996 (Demirel 2017, 125).

point of vision to bring medical knowledge, public health, and market (Kwankam 2004, 800).

The emphasis on information technology in health contributed to the commercialization of the notion of health and normalized patient-centeredness in health policies.[7] Patient engagement to medical knowledge in a large-scale lead to patient consumerism (Lupton 2013, 258). Development of wearable technologies, tracking devices of healthcare status, and popularization of medical knowledge through various communication channels (social and conventional media) have deepened the promotion of e-health and strengthened the patient/consumer-centered healthcare perception (mckinsey.com "digital transformation in healthcare 2019; Nelson et al. 2016, 365&371). To put it in a different way, this changing nature of power relations in healthcare shifts positions of stakeholders in healthcare policies. While doctors should be the determining stakeholders, patient-oriented understanding has removed doctors from this position and made them "stewards" of medical knowledge. An empirical research conducted on diabetic patients in the United Kingdom demonstrated that including patients to the process of producing medical knowledge through internet depended information systems or tracking devices led problems between patients and doctors when the issue comes to demanding unnecessary tests or drugs by doctors (Taylor, Hons, and Bond 2012).

Due to the WHO's agenda of promoting e-health, the European Commission has also been benchmarking it to deploy within its all member states and candidate countries (European Commission 2010, 12; Codanone and Villanueva 2013, 9). However, in the latest report (2018) regarding the adoption and outcomes of e-health applications by member states, it is mentioned that the usage of information systems in healthcare services has a negative impact on doctor-patient relations because of the increasing workload of doctors (Lupianez et al. 2013, 40). In addition to that, according to survey results conducted among member states' 425,622 general practitioners, %41 of the participants declared that the usage of information systems created no change in doctor-patient relationships, while %17 think that it affects the doctor-patient relationship negatively (Lupianez et. al. 2018, 81).

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[7] Although it is a fact that the use of information technologies in health has led to significant improvements in hospital management in terms of treatment and drug production, it is discussed here in terms of the effect it has on patient-doctor relations.

According to these results and researches, empowering patients through various information systems and relocating the axis of healthcare policies centered on the patients as healthcare consumers, it can be argued that commodification of healthcare policies through patient empowerment methods has transformed medical specialists and institutions of healthcare policies into stewards.

4.2. Stewardship in Healthcare: Transforming Medical Labor

The technology of the self, self-care, and consumerism are the key anchors of neo-liberalism (Peters 2007, 173). Although the "cultivation of self "is an important sphere of the modern theory of politics, which is coming from ancient Greek thinkers[8], Michel Foucault's conceptualization of "invention of man and subjectivism" reveals itself as a significant feature of neo-liberal era. Foucault's interpretation of governance and critique of neo-liberalism suggest that execution of power on individuals goes beyond state authority (Peters 2001, 73). Neoliberalism disembarks the state-centered allocation of power and redistributes it to inter-subjectivities through consumer-citizenship filled discourses (Miller 2018, 110-111). In the context of healthcare politics, neoliberal individualism brought the patient-consumer centered, demand-oriented, and governance adapted "integrated healthcare" implementation to various national, regional, and global healthcare policies (Rensburg, Rau, Gourie, and Bracke 2016, 1).

The HTP increased different sorts of patient empowerment applications via healthcare information technologies and privatization. Concordantly, the stewardship practice and good governance have tailored medical specialists and prepared medical students for a market-oriented healthcare system through encouraging over professionalism and elasticizing labor market (Ibid, 3). This claim is echoed in one of the important medical anthropology works in the literature called "This Is Not Medicine" (Tıp Bu Değil). Doctor İlknur Arslanoglu, the editor of the book, argues that current medical education is damaging to holistic medical knowledge and adversely affecting

[8] According to Foucault seeking self-care is described with employing larger amount of medical terminology in ancient Greek culture. Keeping soul and physical posture well and avoiding sickness (disorder) is a notable content of discourses of ancient philosophers (Foucault 1986, 54-58).

doctor-patient relationships due to the extreme professionalization paradigm (Arslanoğlu 2012, 134).[9]

In the 2000 report on the world health, WHO proposed stewardship as the most critical function for improving healthcare systems (WHO 2000, ix). The report highlights the importance of embodying private healthcare servicing and private financing in healthcare systems. Thus, the report offers stewardship as a crucial philosophy to engage all nations to reach the global objective of improving the performance of healthcare systems:

> "Health policy and strategies need to cover the private provision of services and private financing, as well as state funding and activities. Only in this way can health systems as a whole be oriented towards achieving goals that are in the public interest. Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. At the international level, stewardship means mobilizing the collective action of countries to generate global public goods such as research, while fostering a shared vision towards more equitable development across and within countries. It also means providing an evidence base to assist countries' efforts to improve the performance of their health systems." (Ibid, xiv-xv)

In the following sections of the report, stewardship theory is defined and used from directly its dictionary account: *the careful and responsible management of something entrusted to one's care* (Ibid, 45*).*[10] However, the "one" in this definition is not only taken place as patient among citizens, but also a consumer as a natural outcome of being a person (Ibid, 51). Moreover, the report replaces consumers/patients as contributors due to their out of pocket spending on their own health; therefore, it projects a great healthcare system mostly around patients (Ibid, 51).

While the report is describing national governments as the primary steward of public interest in healthcare, it also disparages governmental management of healthcare policies because they have abundant bureaucratic procedures and not involving

[9] In the same study another medical specialist Dr. Uğur Yılmaz supports this claim of Arslanoğlu and points out that development of advanced medical technology and cartels lead doctors over-professionalization or unnecessary treatments (Yılmaz 2012, 234).

[10] Although World Health Organization employed the term only from a technical definition, stewardship is also mentioned in the Christian jurisprudence to provide a basis for private property. Accordingly, God appointed man to carry out its own legacy with its own wealth (Armstrong 1997, 19). Moreover, in the Islamic law, the organization of Hisba is a stewardship organization based on trusteeship and public interest runs by Muhtasip (Taymiyya 1987, 6).

citizens/consumers as a stakeholder of healthcare policies (Ibid, 120). According to the WHO, to make a healthcare system reach its greatest level it must be cost-effective (Ibid, 52). For this reason, the report is suggesting to governments intervening or investing only disease control or detainment, while providing fairness of contribution among citizens (Ibid, 54). Although it seems very paradoxical, the report is solving this issue by proposing private stewardship and encouraging private investment in other areas of healthcare (Ibid, 83-84). As it is stated as exactly in the report:

> "Many factors may alter the actual cost-effectiveness of a given intervention program during implementation. These include the availability, mix, and quality of inputs (especially trained personnel, drugs, equipment, and consumables); local prices, especially labor costs; implementation capacity; underlying organizational structures and incentives; and the supporting institutional framework." (Ibid, 55)

The HTP has initiated and formulated under these prescriptions of the WHO. The stewardship theory in this context is a "nexus" among privatization of healthcare services, locating "consumers" at the center of the healthcare system, and dismantling healthcare workforce from healthcare policies as a stakeholder.

Saltman and Ferroussier-Davis read and promote this report by demonstrating stewardship as a vital need for overcoming challenges of welfare state toward neo-liberal consumerism. Accordingly, they claim that the stewardship is a new policy formulation model, which goes beyond monopolistic state authority in healthcare (Saltman and Ferroussier-Davis 2000, 732). Saltman and Ferroussier-Davis argue that a new state role should be defined to escape from Weber's "iron cage" (bureaucracy). From this perspective, stewardship is a framework of the realignment of interests between public and private realms. Pro-stewardship arguments roots from public choice economists' premises, which implies that public officials/civil servants do not serve to the state but their own self-interest (Ibid, 732).

Henry D. Kass treats stewardship in response to challenges of agency theory. According to Kass, an actual trusteeship relation between state and its official servants is not possible unless the "fiduciary" norms are about their own interest (Kass 1988, 22). However, for Kass, stewards could be an "agent" who is both effective and moral at the same time (Ibid, 28). As in the WHO's report, there is a discrepancy based on the qualifications of the steward itself. First, why a public servant cannot be moral but a

steward? Second, how can a steward be ethical and effective at the same time? For Kass, the American public policy administration failed because servants' professional autonomy extended due to their "esoteric" knowledge. Accordingly, to solve the problem, Kass is offering to decrease professional autonomy in public services and enforce them to be accountable, responsible, and limited towards laws and regulations (Ibid, 35-37).

In the case of Turkey, although the WHO brought the theory of stewardship into the literature in 2000, the first trace of the translation of the concept is encountered in 2007. In 2007, Dr. Julio Frenk Mora, who is one of the former candidates of presidency of the WHO, wrote an article about the concept of stewardship for the "SD Sağlık Düşüncesi and Tıp Kültürü" Journal.[11] In this article, Mora translated stewardship in Turkish as "vekilharçlık". According to Mora, the role of the MoH is being steward of healthcare finance and service delivery. In order to ensure and sustain stewardship position in healthcare policies, the MoH needs to take a meta position in finance and decentralize service delivery (Mora 2007, 48-51).

When the literature of the MoH deeply examined, it is seen that the Ministry employed the concept of stewardship as "vekilharçlık" first in 2010-2014 Strategic Plan. According to this plan, as the Mora suggested in 2007, the Ministry located itself as the steward of healthcare finance and a nexus for cooperation among "sectors" (T. C. Sağlık Bakanlığı n.d. 50). Moreover, in the following Strategic Plan for 2013-2017 term, the Ministry kept its location in the healthcare policy framework and to remain in this position it specifically designated improvement of governance (T. C. Sağlık Bakanlığı 2012, 124).

Throughout the HTP and newly applied stewardship via decentralization in healthcare management[12], medical specialists' holistic-esoteric knowledge has been decreased by promoting over professionalism, their professional unity separated through competitive working conditions, and they bounded to internationally driven quality standards via internationalizing national healthcare policies hand in hand of the WHO and WB. For instance; "accountability" pillar of the government has altered the way of how states governing their healthcare systems. Carolyn Hughes Tuohy, in her study

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[11] This journal belongs to the foundation of Education, Health, and Research in Turkey (Türkiye Eğitim Sağlık ve Araştırma Vakfı –TESA). This foundation also interlinked with the "Medipol Hospital", which is one of the biggest hospital chain in Turkey, which is owned by the current Minister of the Health of Turkey (http://www.sdplatform.com/Sayfalar/98/Kunye.aspx 2019)

[12] This interpretation is expressed even by the formulators and promoters of the HTP (Akıncı et al. 2012, 24).

"Accidental Logics", alleges that the "accountability" in the healthcare systems has changed contract models of healthcare employees. In the older forms of the governing healthcare, there was a "hierarchy-based" model between the state and service providers such as doctors, hospitals, etc. In the hierarchy based models, the state was financing healthcare and distributing its power to medical professionals. However, with the enhanced information technologies, the costs of "medical information" had decreased, therefore, private actors have included the healthcare systems as well as public payers. Consequently, the contract models have started to develop, thus states' roles minimized and the doctors have lost their autonomy by becoming stewards of medical knowledge.

From the perspective of governance, stewardship is an effective model of configuring state and private interest through including private stakeholders and relocating state's role as a policy adviser (Armstrong 1997, 7). Relocating state's power on healthcare policies through stewardship model brings out the concern of eliminating sovereignty and independence of national healthcare policymaking process by opening national institutions to international agencies and corporations (Krassner 1999, 49). In this regard, the stewardship is coming out as a system leads to public-private partnerships. Jim Armstrong claims that stewardship nurtures a hybrid model, which links corporations (both national and international) and governments (Armstrong 1997, 10). However, it is important to note that corporations work for increasing shareholders' profits, in contrast to that, governments should provide social welfare for all citizens.

Armstrong also points out hybrid systems are vulnerable to political patronage. In other words, a strong parliamentary democracy to sustain trusteeship between government and its steward and pursue a certain policy (Ibid, 35). As I have mentioned above sections, Tim Dorlach's research about Turkey's Pharmaceutical policy and reforms in 2009 shows us how populism affects the relations among government and pharmaceutical stewards within one night (Dorlach 2016, 58-59). The HTP has employed many aspects of stewardship from public-private partnership agreements for the construction of new hospitals to the privatization of providing different sort of healthcare services. However, it should be noted and asked that "are capacities of all states' enough to employing stewardship?" As analyzed and highlighted above countries such as Turkey with a lack of democracy and having a patrimonial state tradition experiences an imbalance between promoting private funding and providing social welfare to all stakeholders in healthcare policies (Saltman and Ferroussier-Davis 2000, 736).

4.3. Policy Change: Transformation, Isomorphism, and Churn

Changing a policy agenda could be identified from various perspectives. However, due to my examinations regarding the literature of healthcare politics in Eastern Europe and Mediterranean countries from the mid-1990s onwards, I came across the fact that the changing of healthcare policies both in the inner state politics and as a globally promoted trend is addressed within a similar linguistic and theoretical paradigm (Walt and Gilson 1994-354). The discourse of "development" and "reform" have been using to define and formulate healthcare policy transformations in contemporary Turkey (Keyder, Üstündağ, Ağartan, and Yoltar 2000; Erdoğdu 2009; Yıldırım and Yıldırım 2011; Akıncı et al. 2012; Stokes, Gürol-Urgancı, Hone, and Altun 2015; Ağartan 2015; yılmaz 2017). Therefore, the theoretical backgrounds are inclined to embrace meta-narratives, political analyses, and structural identifications in these studies. However, herein, the very aim is to illustrate the theoretical distinction between the discursive mechanism of policy changing and transformation of the notion of healthcare services on the part of the main policy formulators of Turkey's healthcare system. Correspondingly, it is important to identify how medical professionals shift toward governance as it adapted to change and attempted to forge new counteractions within the boundaries of institutional frameworks.

Therefore, it is crucial to discover the complexities of the process of institutional change as new discourses are created and policies are implemented by the Justice and Development Party since 2003 onward. In this regard, issues of discourse, power, and culture are also central to this thesis as well as economy politics of transformation in healthcare services. Theorizing the change stresses the way in which new social arrangements are constructed as a result of the repression, subordination or incorporation of healthcare professionals with the outcomes of the HTP.

4.3.1. Discursive Institutionalism

In the post-World War II period of the political science discipline, the theory of institutionalism has become more prevalent due to relative failures of individualistic and rational choice oriented theories (Peter 1999, 1). From this perspective, it would not be wrong to claim that institutionalism shaped the applications and adaptations of the

Keynesian welfare state until the beginning of the 1970s (Kuş 2006, 491-492). Ellen M. Immergut argues that the basic differentiation in comparative public policy is the variations among different nations' institutional frameworks and institutional/procedural relationships (Immergut 1992, xiii). Likewise, James G. March and Johan P. Olsen claim institutions are political productions and outcomes of social existences; rather they are political actors that have institutional autonomy (March and Olsen 1984, 738-739). As it is presented in the introduction chapter, institutions of healthcare politics in Turkey are considered as the backbones of the healthcare policies and occupational environment of primary stakeholders, i.e. medical specialists. In the theoretical account of the thesis, I contend discursive institutionalism to illustrate the institutional change in Turkey's healthcare system.

Although the theory of institutionalism itself lays back to ancient philosophers, as March and Olsen depict that the new institutionalism is not a very independent school of thought via-a-vis its old version (Ibid, 738). However, March and Olsen included three major branches to explain the role of institutions and their impacts on political behavior in politics (Immergut 2006, 240). These are rational choice institutionalism sociological institutionalism and historical institutionalism (Hall and Taylor 1996, 5).

The rational choice account of the institutionalism focuses on explaining how institutional codes influence political actors' "strategic" actions (Immergut 1992, 20). In contrast to an agency-oriented branch of institutionalism, sociological institutionalism counts the possible impacts of socio-cultural norms and social interactions on both individual's action and institution making process (Wiener 2006, 39). Historical school of institutionalism deals with greater structures while containing traditional paths of institutions. To put it another way, historical institutionalism makes macro analyzes (Thelen 1999, 379) and perceives institutions as the articulated outcomes of struggle among actors" (Thelen and Steinmo 1992, 2). However, these three approaches have not enough tools to explain the process of "institutional changing". According to Immergut, while rational choice institutionalism is limiting itself by exerting micro-economic analyzes to explain individual choice, sociological institutionalism premises norms and as codes of inter-subjective or inter-organizational 'operating procedures' (Immergut 2006, 241).

Although this thesis acknowledges the importance of the basic principles of historical institutionalism to the definition of the institution and the role of institutions in politics, it employs discursive institutionalism to understand the change of institutions

from a more contemporary paradigm. Vivien A. Schmidt attaches the fourth dimension to institutional theory. Discursive institutionalism conceptualization regards discourse as a foundation, which individuals are interacting for political purposes in the institutional coherence (Schmidt 2011, 67). From this point of view, institutions could be elucidated structures that are more dynamic and fluid. Because, as Daniel Beland put forward, public discourses based on ideas are convincing materials for policy-makers, public, and interest groups (Beland 2009, 705). In other words, institutions are not only constituted from constant cost-benefit calculations, norms or historical backgrounds. Institutions are composed of variational policy paradigms, which are framed by policy-makers according to aims of particular policies (Hall 1993, 277-279).

However, discourses/ideas can also constitute guidelines for individuals to determine their preferences and demand policy change (Schmidt 2011, 48). So, how does this institutional change occur by means of discursive institutionalism? According to Schmidt:

> "…discursive abilities are essential to explaining institutional change because they refer to people's ability to think outside the institutions in which they continue to act, to critique, communicate, and deliberate about such institutions and to persuade one another to take action to change them, whether by building "discursive coalitions" for reform against entrenched interests in the coordinative policy sphere or by informing, orienting, and deliberating with the public in the communicative political sphere."(Ibid, 56)

This formulation of institutional change overlaps with the counter-movement theory of Karl Polanyi. Nevertheless, in the case of the transformation of Turkey's healthcare institutions and healthcare policies, we have witnessed to the other side of the coin. The Justice and Development Party government created the discourse of the need for a neoliberal transformation of the healthcare system and promoted it through sorting welfare coalitions out.

4.3.2. Transformation of Institutions

The institutional transformation has been running in the healthcare and social policies are not one-sided, progressive or economically structural in the 21st century's neoliberal era. As Karl Polanyi addresses in his breakthrough study, *The Great*

Transformation, the transformation itself exists toward a counter-movement that is the self-protection movement of developed by the individual and society against the damaging effects of the free market (Polanyi 2001, 80&136&194). Polanyi's theory of "double movement", institutional and individual actions and interactions could not be understood by disassociating from social, cultural, and organizational circumstances that are surrounding the particular societal existences (Ibid, 164). According to Polanyi, the economy should be "embedded" to society (Ibid, 60). However, to "disembed" economy from society, a legislative and managerial intervention of the state has circled the self-regulating market through the 19th century (Ibid, 135). By then, "fictitious commodities" called as land, labor, and money located as the dominator of the society (Ibid, 79). I claim that this conceptualization of Polanyi could be revisited to analyze the reconceptualization of welfare state and governance and their impacts on the subjects of transformation. In contemporary neoliberal economics, social rights of citizens and employees are commodified and bounded to the voluntarily charity-gift giving institutions of the private sector.

Since the end of the 1980s, the WB has defined the concept of governance as decreasing the weight of the state from the market and the process of public policy-making through participating with more stakeholders (World Bank 1989, 60-61; Newman (Newman 2001, 2). That is to say, by introducing the notion of participation, governance, in theory, leads to the demarcation of state and market. However, by the end of the1990s, the WB has renewed its definition of governance by framing the definition under direct monitoring and steering role of the state (World Bank 1997, 29). As Ayşe Buğra puts forward, in the1990s, the concept of good governance, just like an upgraded version of governance, has started to embrace a "noneconomic intervention" to resume governance-based market economies such as structuring the legislative mechanisms and elasticizing labor markets (Buğra 2007, 175-176). The concept of good governance has built a discourse of participation among civil society, private sector, and governmental apparatus on the basis of providing social assistance through social "entrepreneurship" and "voluntarism" (Ibid, 177). However, due to the temporal inversion of the governance applications, it comes out that the estimations based on wishful endorsements of civil society and private sector towards the welfare of society caused fictitiously commodification of rights embedded in the life (Ibid, 187).

4.3.3. Governance Failure

Gerry Stoker claims that whether the theory of governance suggests a "local democratization" of public services through the steering of various stakeholders rather than direct control of the government, some major social rights, such as the right to health, are seen as part of national citizenship (Stoker 2004, 177). In authority-based regimes, engagement of centralism and governance gives birth to the model of "steering centralism" (Ibid, 221). According to Stoker, transferring more freedom to non-governmental stakeholders as setting centrally tailored high performance-based standards in public policies, which are seen as a right of being a national citizen, could cause various complications and disagreements regarding the formulating and delivering of these services (Ibid, 222). Janet Newman also claims that significant conflicts and challenges came out during the adaptation process of governance in the National Health Service in England and this issue has continued to be an indicator of labors difficulties in securing centrally intended transformations (Newman 2001, 3).

Bob Jessop also points out the fact that universally shaped governance mechanisms must "stabilize" the inconsistencies among different sort of actors while promoting a forced common worldview (Jessop 2000, 17). While the governance strongly proposes concepts of partnership and "heterarchy" among stakeholders instead of hierarchy, it also ties its sustainability to mutually increasing interests, reducing the cost of interactions, and complex interdependencies (Ibid, 18). For Jessop, governance fails or may fail due to "oversimplification" of the lack of knowledge about relative conditions affecting the object of governance (Ibid, 19). In the case of healthcare, it is the relative autonomy of healthcare specialists due to the nature of their knowledge, which is creating difficulties to measure their actions (Newman 2001, 99). For this reason, to place governance related common neo-liberal norms and principles into social policy institutions, governments need to limit the autonomy of medical specialists and change institutional characteristics and organizational structure of healthcare policies.

4.4. Isomorphic Healthcare Policies in Turkey

Deductions made by Jessop and Newman validate themselves through trending concepts of "managers" and "professionalism" in contemporary Turkey as well as in Europe. Likewise, private medical schools; new departments called "health management" have been establishing in universities to separate management of hospitals from chief physicians and hand it over to "appointed" managers. Furthermore, the medical profession itself has been subjecting to various stratifications under heavy pressure of market principles, bureaucratic auditing, and competitive working conditions related to the empowerment of patients (Saks 2015, 144). While some medical specialists establishing counter alliances towards the outcomes of transformation, some of them are internalizing the competitive values and making alliances with the pro-changing discourse.

The institutional change from top to down with steering centralism and its side effects under failing governance applications shows us the transformation of healthcare services in contemporary Turkey could also be analyzed through the theoretical framework of "institutional isomorphism". The theory of isomorphism is actually produced to identify formulation, implementation, and depicting challenges of *organizational change*. In their prominent study, Rosabeth Moss Kanter, Barry A. Stein, and Todd D. Jick put forward that organizations are composed of networks and coalitions constructed by bargaining among different interest groups (Kanter, Stein, and Jick 1992, 47). Following this definition, they argue that in the era of governance of post-1980s, stakeholders are keen to change the control of political power due to the performance of interest sharing mechanisms (Ibid, 233). Form of change, in this competitive logic, leads organizations/institutions/governments adopting or transferring common policy changing to sustain coalitional legitimacy of stakeholders (Ibid, 212). In this regard, isomorphism could be identified as the trend of becoming alike (Radaelli 2000, 26). Kanter and Stein give the example of England's privatization of public services through takeovers through the 1980s (Kanter, Stein, and Jick 1992, 234).

DiMaggio and Powell in their paper *Iron Cage Revisited* identifies three modes of isomorphism: coercive, mimetic, and normative. In the case of Turkey's transformation model, what we have been witnessing is overlapping with these three strands of isomorphism in various levels. As DiMaggio and Powell stated, "peripheral nations are far more isomorphic –in administrative form and economic pattern" (DiMaggio and Powell 1983, 152). Coercive isomorphism describes the direct political pressures or decisions that initiate the change in the organizations' structure and behaviors (Ibid, 150).

Tim Dorlach gives the example of the Justice and Development Party's neo-liberal populist identity in the legal and financial changing of Turkey's pharmaceutical policy in 2009. Dorlach asserts that Turkey's "business-friendly" pharmaceutical policies until 2009 suddenly changed into anti-free market regulations through a direct political reform (Dorlach 2016, 58-59). A similar evaluation also made by Barış Alp Özden by stressing the fact that the welfare regime of Turkey has been abolishing by transferring social policy responsibilities to a team of pro-government charity organizations and coercing government institutions to collaborate with this changing (Özden 2018, 236).

Mimetic isomorphism is also produced by a coercive political authority in the case of lack of know-how information. DiMaggio and Powell claim that if the policy environment is ambiguous, political authority enforces institutions/organizations to imitate other model organization's way of policy changing modes (DiMaggio and Powell 1983, 151). Turkey's implementation of the HTP is a form of macro imitation. The Justice and Development Party adopted the WB's prescribed policy changing methods under the meta-narrative of good-governance and implemented the WHO's healthcare goals to its own transformation plan without taking any consideration of inner stakeholders. The third type of isomorphism is actually an outcome of the isomorphic change process. Normative isomorphism can be defined as a response undertaken by members of occupation towards isomorphic changing of that particular occupation (Ibid, 152). According to DiMaggio and Powell, this type of isomorphism mainly derives from the professionalization of the workforce (Ibid, 152).

4.4.4. Policy Churn

Although the HTP has a "transformation" concept within itself, as far as I analyzed the program is not designed to transform the healthcare system through its own dynamics, rather than that it is formulated to adopt international organization's neo-liberal policies without considering probable damages to Turkey's welfare regime. Formulation and implementation of the program are perpetrated by the monopolistic approach of the Ministry of Health and any counter-movement by dissolving doctors' occupational conditions. In other words, this process of "alleged transformation" aims to block the possibility of double or counter-movement towards the HTP. Policy churn and advocacy

coalition frameworks are effective tools to understand the program's occurring stages and reinforce the theory of isomorphism.

Policy churn is defined "*as changing policy without establishing a clear link between the reasons for the failure of the existing policy and how these will be overcome by the new policy*" (Monios 2017, 352). This definition of policy churn shows us the need for distinguishing variations of policy changing terminology. Therefore, policy churn differs from another sort of policy transformations "*as it derives not solely from the boundedly rational seeking of better policies (the way policy transfer is generally characterized) but from processes of institutional isomorphism*" (Ibid, 352). From this point of view, the conceptualization of policy churn overlaps with the main argument of the thesis. The HTP is a practical example of isomorphism.

As stated above, the theory of isomorphism emanates from an uncertain institutional environment. In the case of Turkey's healthcare system, it is important to note that the initiation date of the program intersects with the Justice and Development Party's accedence and post-2001 economic crisis. The Justice and Development Party were not very hegemonic in public policy-making mechanisms (Öniş, 2018, 4). For that reason, the policy environment was very open to external actors' dominations and tend to adopt different institutional environments.[13]

It ıs a fact that both organizational and bureaucratic formation of Turkey's system was very complicated and unwieldy. However, the current healthcare system that has structured by the HTP shows very symptoms of a uniform structure within the framework of global neoliberal principles. Latin American countries have also had a similar transformation process. After the Alma-Ata declaration of the WHO, structural adjustment packages prescribed by the IMF and the WB. Therefore, neoliberal reforms restructured national healthcare systems in Bolivia, Ecuador, Chile, Brazil, Argentina, Uruguay, Mexico, Nicaragua, Honduras, and El Salvador on behalf of effectiveness and development (Hartman 2016, 2148). In this regard, neoliberal reforms in healthcare systems of various developing countries constitute samples of policy changing similarities. Thus, as DiMaggio and Powell argue, legitimacy of ravaging healthcare systems comes with the similarity (DiMaggio and Powell 1983, 158).

[13] Ata Soyer also presents an inner perspective regarding the 2001 economic crisis and its impacts on the healthcare system of Turkey (soyer 2004, 228&265).

Julie Walters, in her study upon the healthcare sector in America, points out 17 federal states have affected each other in the context of institutional isomorphism. American elder-care services (assisted living sector) as a sub-policy field of the healthcare system has produced its own regulatory policy framework through institutional isomorphism and advocacy coalitions (Walter 2012, 460). According to Walters, organizations' life cycles have diverse mechanisms and original structures. However, through new phases in the policymaking process "*homogenization with other organizations within the environment*" is inevitable (Ibid, 461). Throughout The HTP, the healthcare system has re-designed within the environment of external financial actors' policy mandates. Thus, The HTP as both reform and public policy went through a long process of regulating and de-regulating deep-rooted institutions of social policy in Turkey. As well as the occurring process, maintaining a newly established system was an important issue for the Justice and Development Party. As it is discussed above, the ideology of governance and stipulations of the WB and the IMF suggested containing private funding in the healthcare system. Therefore, new coalitions among private and public actors have nurtured in the policy-delivering environment of healthcare in Turkey.

4.4.5. The Advocacy Coalition Framework

The Advocacy Coalition framework refers to a coalition of groups that come together for a shared set of interests or beliefs about an issue (Birkland 2007, 69). The most cited theorists of this theory, H. Jenkins-Smith, and Paul Sabatier asserts that advocacy coalition framework premises three principles: policy change needs an interval of time, policy systems consist of subsystems, which are composed of different institutions or authorities, and value priorities (Sabatier 1988, 131; Weible and Sabatier 2007, 123).

Process of neoliberal transformation of healthcare in Turkey started in 2003 and major changes completed in 2013, in the very first draft of the Emergency Action Plan, every aim or step of the HTP was correlated with different institutions and policy actors. The core belief system was the need of changing healthcare policies for the benefits of citizens. As a combination of these three premises, the Justice and Development Party government came together from various actors (external and internal) interest groups such as the WHO, WB, IMF, private hospitals, and non-governmental organizations.

Another theoretical discussion about healthcare policies and advocacy coalition framework made by Sebastian Princen, in his article upon internationalization of healthcare systems and the Advocacy Coalition framework. Based on the Moravsick's ideas about international collaboration, Princen claims that the concept of "political opportunity structure" provides a policy area, which includes external policy actors such as the WHO (Princen 2007, 19). Likewise, for Sabatier, "dynamic system occurrences" such as changes in socio-economic conditions, changes in systemic governing coalitions, policy decisions and impacts from other subsystems may also influence or cause policy changes by external policy actor within a subsystem (Sabatier 1988, 136-137).

Volkan Yılmaz in his book specifically focuses on the impact of the WB into Turkey's healthcare policies. Yılmaz claims that Turkey's partnerships between the WB and Turkey in the context of healthcare policies have started in the 1990s by direct project loans. With the start of the Justice and Development Party government, these partnerships have deepened in the context of both paradigm and financial levels. Yılmaz quotes from WB's 2003 report, called *"Turkey: Greater Prosperity with Social Justice",* that WB gives the idea that imposes finance and delivery mechanisms of healthcare services should be separated and expresses its enthusiasm for helping to a policy change in Turkey. Thereafter, the MoH and the WB started "*health transition project*" in 2004. The project lasted until 2007 and included a 61 billion Dollars loan to Turkey (Yılmaz 2017, 126-127).

4.5. Turkish Healthcare Policies and the EU

Focusing on Turkey's contemporary situation of social and healthcare policies through its engagement with the EU is one of the reasons that distinguishes this study from others existing in the literature. Because, when we survey the existing literature about healthcare policy, social policies or politics of welfare states, we see that the mainstream studies focus on 'only' countries or regions prone to "developed" policy systems from Western Europe to North America (Saltman, Busse, and Figueras 2004; Wendt 2009; Jacops and Skocpol 2016). For instance, Heinz Rothgang and his colleagues' book comparing OECD (Organization for Economic Cooperation and Development) countries' healthcare systems is one of the contemporary studies

(Rothgang et. al. 2010). Yet, Turkey has not covered in this book, even Turkey is one of the 20 founding members of the OECD (oecd.org “Turkey” 2019). The reason for Turkey’s exclusion is presented as the lack of standards of being a democratic constitutional welfare state (Rothgang et al. 2010, 8). However, there are also studies focusing on developing countries or emerging market economies in the context of reform policies and impacts of occurred reforms in healthcare policies (Wlat and Gilson 1994; Kruk and Freedman 2008; Siddiqi 2009).

While the literature generally takes Turkish social policies and healthcare status into consideration / comparison among Latin American or East Asian countries[14], in this thesis, I adopt Ian Gough’s approach regarding the positioning of Turkey in a regional manner. Thus, Turkey is evaluated through its relations with the EU under the South European network. There are two reasons for this choice. Firstly, even though Turkey has had a long shared history with the EU (formerly European Economic Community), with the Justice and Development Party government relations have followed a more fluctuated course. Regarding this fact, the EU impacts on Turkey’s social policies were visible.[15] Secondly, the EU was one of the first non-financial and supra-national organizations that has adopted a governance policy and implemented it on its Acquis Communautaire (European Commission 2001, 5). Therefore, both parties have been exposed to similar neo-liberal adjustments in their social systems, especially in the healthcare policies since the 1990s. For instance, as well as Turkey, one of the most important healthcare policy change in the EU was the adoption of stewardship policy by inducement of WHO (Saltman and Ferroussier-Davis 2000, 732-739; WHO 1998, 32; Kickbush and Gleicher 2012; Falkner 2016, 274). Moreover, theoretically, as I have indicated through Andrain’s perspective, the EU’s impact on Turkey’s internal policy areas shows a layer of internationalization of healthcare policies.

[14] The reason of this situation is the economic deterministic approach. Turkey, Latin American, and East Asian countries had regarded in the same cluster, as developing countries, due to their close Gross Domestic Product and development rates.

[15] Although the contemporary situation of membership negotiations seem to be frozen, the topic of “Health and Consumer Protection” has still been moving forward between two parties.

4.5.1. European Union Enlargement and Social Policies

On 9-10 December 1991, the European Council held the "inter-governmental conferences" with its twelve member states (europa.eu "EU History" 2019). By this meeting, they had agreed on a common Social Policy agenda, except the United Kingdom (EUROFOUND 2013). In 1992, member states agreed, signed and declared the Treaty of Maastricht. Treaty of Maastricht had constructed three pillars for the "political union". The Last pillar of the union was "cooperation on the justice and home affairs" (Treaty on European Union 1992, 8). Throughout these constructive actions on building the "European Citizenship" notion, the European Community also enhanced the roots of its own constituent Treaty of Rome (1957) on behalf of social policies. According to the first article of the Social Policy chapter in the Treaty of Maastricht, "*The Community and the Member States shall have as their objectives the promotion of employment, improved living and working conditions, proper social protection, dialogue between management and labor*" (Ibid, 197). With 1997 the Treaty of Amsterdam, on the "Protocol on the Position of the United Kingdom and Ireland", United Kingdom had agreed to annex Social Chapter of the Treaty of Maastricht (The Treaty of Amsterdam Amending The Treaty on European Union 1997, 99-100).

2007 is another prominent date for European integration. In 2007, the Treaty of Lisbon signed and entered into force in 2009, when all the 27 member states ratified it. When we examine the Treaty, it is seen that the social policy issues arranged in article 151 and 152. In the article 151, the treaty recognizes The European Social Charter of 1961 and The Community Charter of the Fundamental Social Rights of Workers. In the article 152, the Treaty recognizes and delegates the competence of member states' national authority over social policy issues (The Treaty of Amsterdam 1997, 99-100) (Bonde 2009, 113). Recognition of the national authority over social policy issues has created a dichotomy especially in the context of healthcare systems.

The EU as a supranational political body had no authority to implement European Union Law in the field of healthcare.[16] In spite of this fact, the EU had started to develop its own health care policies under the 'emergent healthcare' and 'public healthcare

[16] According to *Treaty of Amsterdam*, "*Paragraph 5 of the article 129": Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care.*

policies'. According to Hervey and Vanhercke, this strategy of the EU is called "patchwork" (Hervey and Vanhercke 2010, 85; Hervey 2010, 5). There is a "binary competence" in between the EU and its member states. Because of that, there is a "double patchwork". The EU is influencing its member states' healthcare policies not directly regulating their healthcare systems but indirectly adopting and using different polity tools such as public health policy. Turkey, as a long-term candidate state, has also been influenced via this double positioning of the EU. It is very obvious that the "Health and Consumer Protection" chapter of the accession negotiation has been the only chapter proceeded regularly since it was opened in 2007. Although healthcare is considering as a right in the Charter of Fundamental Rights (2012, 43), the EU is putting the notion of health in the same basket with the topic of "consumer" protection (ec.europa.eu "Health and Consumer Protection 2018).

Following fifth and the last enlargement wave, Turkey's accession process has been going through a stagnant period. Although, most of the chapters are frozen, issues of healthcare and consumer protection are demonstrated as progressed issues in various progress reports. Dubois and Mckee, in the context of the fifth enlargement, suggests "convergence" hypothesis to understand the EU impacts on the candidate countries' healthcare policies. According to that, once all candidate countries entered to the accession way, they embark all values and institutional codes of the EU. In other words, polity tools of the EU such as pre-accession treaties, harmonization packages, conditioning the adoption of the acquis are mainly aiming to converge national policies of the candidate countries (Dubois and McKee 2004, 45).

4.5.2. The EU Impact on Turkey's Healthcare Policies

Indeed, it is seen that the EU's patient/customer-centered healthcare understanding is reflected in the accession process itself. While the accession process continues through various chapters (exactly under 35 chapters), the chapter of Consumer and Health Protection has opened as the 28th chapter in late 2007 (ab.gov.tr "Current Situation" 2019). This chapter is screening Turkey's alignment performance regarding the EU's regulations on product protection, consumer rights, communicable diseases, blood transfers, tobacco products, and cancer (ab.gov.tr 2019). Although the Commission screens Turkey's social policies and employment conditions under different polity tools,

currently there is not a concentrated chapter focusing only on 'public health' and 'health system'. Due to the Commission's positionality on the screening process of Consumer and Health Protection, the EU's influence on Turkey's healthcare policies is alignment with free-market principles as well as with other candidate countries. The EU aims to ensure market surveillance notion in medical products such as technological devices and pharmaceuticals. (Commission of the European Communities 2007, 33; European Commission 2017, 15). In addition to this, general public health measures such as life expectancy, infant and maternal death rations, bed quantities in hospitals, and health expenditure per capita.

Table 4.1. Turkish Healthcare Snapshots through the EU Progress Reports

Year	Commission's View on 28th Chapter
2009	"The Regulation on market surveillance of products has been amended in order to harmonize the safety testing practices of different market surveillance authorities."
2010	"In the area of consumer protection, more efforts are still necessary, in particular on non-safety related issues, to strengthen the consumer movement and to ensure proper enforcement of consumer protection in general. In the area of EN 93 EN public health, there has been good progress in terms of legislative alignment."
2011	"Financial and human resources need to be allocated for market surveillance activities, and cooperation with consumer NGOs needs strengthening."
2012	"As regards horizontal aspects, the ongoing institutional reform of the health system has led to improvements in the **administrative** capacity of the Ministry of Health."
2013	"On horizontal aspects of public health, the institutional reform of the health system has been completed at the central level. Preparation of operational procedures for the local level management structures is continuing."
2014	"On horizontal aspects of public health, the institutional reform of the system has resulted in multiple responsible organizations at the local level, requiring a coordination mechanism for better management, especially for monitoring and evaluation. Preparations in this area are well on track."
2015	"Public health in Turkey has generally improved. The quantitative capacity of health services improved, including the number of doctors per capita. Life expectancy at birth has risen to76.9 years from 72.4 years in ten years."
2016	"On public health, the increasing number of refugees is putting a heavy burden on the healthcare system."
2018	"With regard to public health, national legislation on healthcare is partly aligned with the EU acquis."
2019	"There is a good level of preparation for legislative alignment of consumer and health protection."

Source: https://www.avrupa.info.tr/tr/ilerleme-raporlari-744 2019.

As it is summarized in the Table 4.1, even in the most turbulent years of the EU-Turkey relations in the post-Gezi protest period (Akdeniz 2013) and Turkey's economic statistics are shaking (European Commission 2019, 4), the Commission's review of Turkey's public health state has illustrated as ongoing increasing of alignment with the EU's regulations. The paradoxical logic behind these reviews lays dormant of the

commercialization of healthcare in Turkey. In the health-related sections of the progress reports, there is not any indication regarding the violence towards medical specialists, out of pocket payments made by patients, worsening working and waging conditions of healthcare employees or decreasing the quality of medical education. However, when we look at the status of these indicators which are not included in the reports, the neoliberal effects of the so-called 'progress' in the healthcare system in Turkey can be understood more clearly.

Turkey has been reviewed as a part of the sixth enlargement together with Southern and East European countries Serbia, Albania, Kosovo, Macedonia, Montenegro, and Bosnia and Herzegovina. According to Eurostat statistics, in 2016, the average public expenditure of member states on health-related to their Gross Domestic Products is %7.8. Hereunder, Turkey's public expenditure on health is %3.5 and it has decreased to %0.4 between 2007 and 2017. Serbia also shows a similar but a greater pattern with %1.0 decreasing of its public expenditure on health between 2007 and 2017 (ec.europa.eu "Public Expenditure on Health Relative to GDP 2019). The health expenditure per capita was 1254 Turkish Liras in 2007 (Sasam Enstitüsü 2017, 13) and increased by nearly %25 to 1751 Turkish Liras in 2017 (Türkiye İstatistik Kurumu 2018). According to Ankara Medical Association, the quotas of the Faculty of Medicine increased from 4941 in 2003 to 14647 in 2018 (Hekim Postası 2018).

The EU's positionality of Turkey's healthcare system is based on standardization of healthcare services, products, and trade rather than healthcare rights or socio-economic situation of healthcare state. As evidence of this argument, developments regarding Turkey's pharmaceutical localization efforts have already gathered negative responses from the Commission (healthpolicywatch.org "EU Disputes New Turkish Rules" 2019).

5. CONCLUDING REMARKS

Throughout this thesis, I sought out to discover the theoretical grounds to discuss the contemporary transformation of Turkey's healthcare system, based on the initial outcomes of the HTP (HTP). Turkey's engagement with neo-liberal economic policies started with the 1980s, which eventually led to the neo-liberal transformation of healthcare policies in the early 2000s.

According to the systematic literature review methodology used in the thesis, it came out that the formulation of the HTP heavily shaped by the WB, WHO, and the EU. As it is outlined in the third chapter, healthcare policies have multi-stakeholders. However, this situation had seen a complexity or an obstacle to overcome by the JDP government. Therefore, through neglecting medical specialists' opinions and possible suggestions, as one of the most important stakeholders, the HTP formulated in an Emergency Action Plan prepared by the party officials depending on the WB's reports in 2003. According to further analyzes conducted throughout the thesis, an external actor of healthcare policy environment, it came out that the contemporary healthcare policies of Turkey have been heavily affected by the WB.

Although the justification discourse of the HTP rested upon the raising basic indicators of healthcare standards, envisioned policy changings transformed patient-doctor relationships radically. Moreover, according to statistical data presented in the third chapter, the HTP has not achieved desired goals generated by its formulation. While the patient satisfaction ratios increased, we encountered a constant raising on the patient number per one doctor, out of pocket payments by patients, and violent incidents against the medical workforce. In other words, the JDP governments' neoliberal reforms did not correspond to their neoliberal agenda as it was expected. Instead, the habitus of being a patient and the occupational positionality of medical specialists are changed. The HTP created a market-oriented healthcare system that commodified healthcare services and

prevailed customers instead of patients through transforming medical specialists into stewards of medical knowledge.

As it is demonstrated in the second chapter, although mainstream theoretical approaches evaluate neoliberal intrusions into healthcare policies as a challenge towards right based welfare regimes and status of citizenship, these approaches fall short to explain how patients are adjusting neoliberal policies while they are exposed to neoliberal commodification of their social rights. In this sense, the theory of patient empowerment illustrated the ways of discussing the transformation of the notion of the patient into “customership” through healthcare information systems.

The theory of governance adapted to neoliberal economic policies by the WB in the late 1980s. Also, the strands of governance had encompassed by the WHO in 1998 by the Alma-Ata Health21 agenda. The main premise of governance is including stakeholders to policy agendas from general state politics to public services. Herewith, both the international organizations and prominent scholars such as Jan Kooiman and Guy Peters argued that through adopting governance the way of managing a state would change from direct control of the state to steering of the state with various actors. On the other hand, as Bob Jessop put forward, in authoritarian regimes transferring social policies to non-governmental policy actors eventuated governance failure and steering centralism. Tim Dorlach’s study on the transformation pharmaceutical sector of Turkey set a convenient example for this argument.

However, in the case of the promotion of over-incorporation of patients within healthcare policies through information technologies, what we witnessed is a transmutation of the perception of being a patient. Therefore, according to research conducted in the fourth chapter, it came out that the theory of patient empowerment may pave the way to contend with this transmutation. Overemphasis and endorsement of e-Health application by healthcare policies resulted in patient consumerism, which led to power shifting between patient-doctor relationships. As the data provided by the EU demonstrated that patient empowerment through information technologies increased the workload of medical specialists’ and negatively affected their engagement with patients. From this point of view, the theory of patient empowerment could be used in further researches on the violence against the healthcare workforce.

Concordantly, the theory of stewardship enabled us to discuss another side of the coin. While patient empowerment based policies put patients-consumers into the center of the healthcare system, as a consequence, the idea of stewardship pushed medical

specialists into the peripheries of the healthcare system. The stewardship theory officially embraced by the WHO in 2000 Report. I unveiled the indoctrinations in the report. Accordingly, the theory of stewardship in the 2000 Report, manifests itself as an ultimate way of improving performance, quality, and cost reduction in healthcare services. The report reiterates the goals of the theory by encouraging the establishment of private stewardship and effective care of 'consumers'. According to Fevzi Akıncı and Salih Mollahaliloğlu, who are the policy formulators and devotees of the HTP, stewardship theory is also adopted by the contemporary healthcare policies in Turkey.

Although these aims are accustomed to neoliberal ideals, as knowledge-based fields of social policy, stewardship created controversial outcomes in terms of the scientific standards of being a medical specialist. Privatization of healthcare services, performance-based, and patient-centered healthcare understanding combined with stewardship theory elicited the concept of over-professionalization in medical knowledge. Even though the concept of professionalization states a positive emphasis in terms of the medical knowledge and occupational competence, this outcome of stewardship causes eradication of holistic knowledge and occupational unity among medical specialists. The eradication of holistic knowledge in medicine defined as a problematic outcome of neoliberal transformation healthcare policies both in Turkey's case and in a global manner. Rensburg and Bracke put forward this problematization in their study on the emergence of integrated healthcare and remarked by the medical specialist İlknur Arslanoğlu in the context of the contemporary healthcare policies in Turkey. Because there is no scientific study on the relationship between the stewardship theory and its impacts on occupational transformation in healthcare, it is suggested for further studies to consider this theory as part of the subject matter.

Both in the formulation and initiation process of the HTP and neoliberal policies introduced by the HTP hitherto demonstrated that contemporary healthcare policies of Turkey are products of certain policy transfers, adoptions, and exactions from three major international organizations: WB, WHO, and the EU. As it is embodied in the exemplifying case research on the effects of the EU on Turkey's healthcare policies since 2007, implementation of the HTP as an institutional changing raised the need for theoretical tool to deal with the question of whether transformation of healthcare institution in Turkey is an outcome of internally determined policy agenda or internationally instigated policy formulation on behalf of different interest groups. While theoretical explanations in the literature confine to explain this situation as an effect of

globalization, the theory of isomorphism presents us with a scientifically more illuminative path.

The theory of isomorphism could provide a comparative perspective regarding contemporary healthcare policies in Turkey. Because as we are taking the discourses of “transformation” and “reform” in the HTP as a given method of policy changing, according to discursive institutionalism, this is a way of justifying the neoliberal paradigm by the JDP. However, when we examined the HTP through the theory of isomorphism, it turned out that the overall implementation of the HTP corresponds to all three types of isomorphism: coercive, mimetic, and normative.

The HTP is an example of coercive isomorphism because it occurred from a top-down attitude of the JDP government without taking any internal main stakeholder’s opinion. Likewise, the program also shows the feature of mimetic isomorphism through the way of its formulation. The JDP government aimed to transform healthcare policies immediately after its first electoral victory without proper know-how but with external directions of the WB. The HTP is a total imitation of the WHO’s 2000 Report and the EU’s benchmarking. In terms of impacts of the HTP on patients and the healthcare workforce, as it is unraveled throughout the study, it shows the symptoms of normative isomorphism. The theory of stewardship points out that medical specialists are aligned with contemporary healthcare policies in the consequences of over-professionalization.

This research was carried out to reveal the theoretical gaps in the healthcare politics literature and to introduce new theoretical approaches. In this context, the next step is qualitative and quantitative researches on the contemporary healthcare policies and the impacts of the HTP on patients and doctors in the light of these theories.

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