MARKETISATION PROCESS OF THE HEALTHCARE SYSTEM: THE CASE OF TURKEY

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Abstract. Health policies and systems are determined by the changes in the world's economic policies. Therefore, the role and the responsibilities of governments in the health sector are also susceptible to change. In this study, given the/ in the framework generated by/ taking into account the implementation of the last 40 years policies in the world, there have been evaluated the transformation process, the finances and the services provided by the public health system, through the lens of the political economic approaches for the health system in Turkey. The transformation of the health system has been seen as a reflection of economic policies that were shaped by the social relations. The focus of this study is the marketisation process of the healthcare system in Turkey.

Keywords: marketization of health care, health inequalities, right of health, health system, Turkey.

Rezumat. Politicile și sistemele de sănătate sunt determinate de schimbările din politicile economice mondiale. Prin urmare, rolul și responsabilitățile guvernelor în sectorul sănătății sunt, de asemenea, susceptibile de schimbare. În acest studiu, dată fiind/ în contextul creat de / luând în considerare implementarea politicilor din ultimii 40 de ani în lume, au fost evaluate procesul de transformare, finanțele și serviciile furnizate de sistemul public de sănătate, prin prisma abordărilor economiei politice pentru sistemul de sănătate din Turcia. Transformarea sistemului de sănătate a fost văzută ca o reflectare a politicilor economice care au fost modelate de relațiile sociale. Accentul acestui studiu este procesul de comercializare a sistemului de sănătate din Turcia.

Cuvinte-cheie: comercializarea asistenței medicale, inegalități în materie de sănătate, dreptul la sănătate, sistem de sănătate, Turcia.

Contents

1. Introduction

Health care is considered to be a fundamental human right, and an equitable provision of health services is increasingly seen as a major challenge for policymakers in the ongoing debate about the coverage domain of health services.

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Health care systems across the world have been implemented through a significant transformation process. Health policies and systems are determined by the changes in economic policies. Neoliberal reforms lead to profound changes in healthcare systems around the world, on the account of their emphasis on free-market rather than the right to health.[3] The rhythm of healthcare privatization depended and depends on the temporal moment and geopolitical place of countries in the capitalist world system[4]. Still, it is the logic of the system that tends to convert public services into commodities to be bought and sold on the private market.[5] Indeed, this is what is called marketization of healthcare, together with education, research, culture, and the other social ends of society and functions of the state[6].

The economic policy approach has turned into a neo-liberal model in the early 1980s in Turkey, the same as all around the world.[7] Therefore the role and responsibilities of governments in the health sector have become arguable and also have begun to be an important subject of change. In the early 1980s, under the concepts of "general health insurance" and "family physician model", privatization of public health services and their overall "liberalization" in parallel with global tendencies constituted the key elements of the Health Reform Programs.[8] There were reform attempts throughout the 1990s under the different ruling governments, and some transformation programs were prepared, but they did not take place as a whole except for a few regulations. However, the Health Transformation Program (HTP) was launched in 2003. This program paved the way for a series of reconfigurations in health care finance, health care provision and regulation of health care market.[9] And the transformation of the health system in Turkey, which was the aim of all governments since the 1980s due to the proposals of local capital groups and international institutions, was largely completed in 2012[10].

This study will explain this process of marketization of Turkey's health-care system. In her epistemological analysis of the relevance of empirical health-care studies in post-communist Romania, A. Bazac states that the mainstream ideology ignores the worsening of the state of health of the majority of the population and its systemic political causes. Because linking this phenomenon to its causes is undesirable[11] according to the neo-liberal healthcare policies and regulations.

The impact of the transformation in health-care in Turkey has already received considerable attention. While the mainstream ideology points out that the transformation has facilitated access to,

[3] D. Sakellariou and E. S Rotarou, "The effects of neoliberal policies on access to healthcare for people with disabilities", *International Journal Equity Health*, 16(1), 2017, pp.1-8.
[4] A. Bazac, "Epistemology of empirical research: the case of the consequences of the Romanian neo-liberal "Healthcare" law", *Journal of Contemporary Central and Eastern Europe*, 2018, p.4.
[5] V. Navarro, *Medicine Under Capitalism*, Prodist, New York, 1976, p.216.
[6] A. Bazac, 2018, p.4.
[7] A. Buğra, "Two Lives of Developmentalism: A Polanyian View from Turkey" in *Development as a Battlefield*, International Development Policy Series No.8, Geneva, Boston: Graduate Institute Publications, Brill-Nijhoff, 2017, p.72.
[8] M. Sütlaş, "Health Transformation Program and the 2012 Turkey Health Panorama", Heinrich Böll Stiftung Türkei, 2012, pp.46-47, https://tr.boell.org/de/2014/06/16/health-transformation-program-and-2012-turkey-health-panorama, February 2019, p. 46.
[9] V. Yılmaz, "Changing origins of inequalities in access to health care services in Turkey: From occupational status to income", *New Perspectives on Turkey*, No. 48, 2013, p.56; E. Cevahir, *Transformation of Health Care System in Turkey: Social Reflection Examples* (Türkiye'de Sağlık Sisteminin Dönüşümü: Toplumsal Yansıma Örnekleri), Kibele Yayınları, İstanbul, 2016, p. 289.
[10] Yılmaz, V., "Changing origins of inequalities in access to health care services in Turkey: From occupational status to income", *New Perspectives on Turkey*, 48, 2013, pp. 56-65; E. Cevahir, *Transformation of Health Care System in Turkey: Social Reflection Examples* (Türkiye'de Sağlık Sisteminin Dönüşümü: Toplumsal Yansıma Örnekleri), Kibele Yayınları, İstanbul, 2016, pp. 289-292.
[11] A. Bazac, 2018, p.1.

and thereby eliminated, the inequalities in healthcare[12], it ignores the public consequences of the universal tendency to privatize healthcare. However, there are some others who raised equity concerns, arguing that the market-based transformation and its reliance upon a social insurance-based financing model may create considerable access barriers[13].

Health is a subjective experience and a complex process, and it depends on the social and economic context besides natural, genetic determinants[14]. Health-care is also a complex process of *prevention*, *treatment*, and *management* of illnesses and disabilities. Accordingly, the access to adequate work and living conditions can be considered as premises of health[15]. So, in this study we focus on marketisation process of the healthcare system in Turkey by taking into consideration the transformation of the health system in its economic and social context.

2. Health Transformation Program (HTP)

The health system in Turkey was based until recently on a structure consisting of state hospitals, SSK (Social Security Institution) hospitals, university hospitals, private hospitals and health centres. By financing this system, in addition to the shares allocated from the state budget, there was a social security system consisting of three social security institutions - Retirement Fund for civil servants, SSK (social security for waged workers), Bağ-Kur (social security for employers and self-employers) and Green Card (for unemployed poor) and also a social assistance system. While civil servants and low-incomers (green card holders) benefited from health services without paying health premiums, SSK and Bağ-Kur residents were benefiting from health services by paying health premiums.

Today, this healthcare system has been radically "liberalized" and transformed. The new health system is based on a "liberal" social policy approach[16]. Since the 1980s, a paradigm transformation has been experienced in public health services with the neo-liberal transformation process. The aim of the Health Transformation Program (HTP) is to transfer all health services to market conditions. Therefore, HTP, which prefers a trade-profit oriented system, where the patient is defined as a "customer" and the hospitals as "health companies", has been put into practice[17]. In the axis of the commodification process in health services, the stereotypes that enable the reproduction and social evaluation of wage labour have been rearranged depending on individual responsibility versus social responsibility and market relations versus collective planning[18].

[12] See WHO, *Successful Health System Reforms: The Case of Turkey*, WHO Regional Office for Europe Scherfigsvej 8 DK-2100 Copenhagen, Denmark, 2012; OECD, *Reviews of Health Care Quality: Turkey 2014: Raising Standards*, OECD Publishing, 2014.

[13] K. Pala, "Neoliberal health reforms in Turkey", *Pre Conference Workshop of IAHPE in Collaboration with TMA*, İstanbul, Turkey, January 14-15 2017; Z. G. Öktem and M. A. Çakar, "What have health care reforms achieved in Turkey? An appraisal of the Health Transformation Programme", *Health Policy*, 119(9), September 2015, pp.1153-1163; Aktan Ö. et al. (2014) "Health-care reform in Turkey: far from perfect", *The Lancet*, 383(9911), January 04, 2014, p.25-26; Civaner M., "Health-care reform in Turkey: far from perfect", *The Lancet*, 383(9911), January 04 2014, p.26; O. Hamzaoglu et al., "Can Health Inequalities Be Reduced through Healthcare Reforms? Turkey's Experience", *International Medical Journal*, 21(1), February 2014, pp.73-76; Yenimahalleli Yaşar G. and Uğurluoğlu E., "Can Turkey's General Health Insurance System Achieve Universal Coverage?", *International Journal of Health Planning and Management* 26(3), 2011, pp. 282-295.

[14] A. Bazac, 2018, p. 5.

[15] A. Bazac, 2018, p. 6.

[16] F. Ataay, "Sağlık Reformu ve Yurttaşlık Hakları", *Amme İdaresi Dergisi*, 41(3), Eylül 2008, p.169.

[17] E. Yeldan, "Sağlıkta Dönüşüm Programı ve Gerçekler", 12 January 2005, http://www.bilkent.edu.tr/~yeldane/Yeldan07_12Ocak05.pdf, Accessed November 2012.

[18] G. Yücesan-Özdemir and A.M. Özdemir, *Sermaye'nin Adaleti*, Dipnot Yayınları, 1. Baskı, 2008, Ankara, p. 216.

The Bbasic components of the HTP are: the transition from health centres to family medicine system in the delivery of primary health care services; transforming secondary and tertiary public hospitals into "administrative and financially autonomous health enterprises" and "city hospital"; in the financing of health services, the transition to General Health Insurance in terms of expanding the premium regime.

2.1. Transformation of primary health care

With the HTP, the structural transformation process of public health services has started and in this line the transition to family medicine system of the public service delivery in the health system of primary health care began in 2005 in one province and, once it has been widespread in December 2010, the family medicine system has covered the whole Turkey. The public authority has been withdrawn out of the role of financing primary health care delivery, by transferring the responsibility of primary care to contracted family physicians.

Before this transformation, primary health care provided permanent health services in the *health centres* which were expanded all around Turkey and first-level doctors in these centres were civil servants with job security. A permanent service was provided in health centres in urban and rural areas[19]. The health centre system based on the Law No. 224 (in 1961), which is organized according to the number of the population, offers preventive medicine services for people and the environment with a holistic approach, and adopts a multidisciplinary service approach with a team service approach, is now replaced by the "family medicine" system.

With this transformation, a new model of Family Medicine is introduced. With the HTP, there is a structural change in primary health care institutions that contradicts the Law No. 224. Primary health care services are privatized in the name of the family medicine system by using the existing health centres infrastructure and considering the supply-demand balance of the free market economy.[20]

In this new model, family doctors work with time-limited contracts and have no job security. Family doctors meet all the costs of the "family health centres" they work in a way that has turned the primary health service delivery into a small private physician enterprise. In the rural areas, the doctors do not have a permanent and stable family health centre for providing primary care. Family doctors provide service to rural areas as a part of mobile service, which limits the access to health services in rural areas.[21] So with the Health Transformation Program, health services became more urban-biased and hospital-oriented.

2.2. Transformation of public hospitals

Structural transformation in public hospital services started to be implemented with the Public Hospital Unions model, which was put into practice in line with "health enterprises with administrative and financial autonomy", which is one of the main objectives of the HTP. With the Decree No. 663 of 2011, the legal regulation regarding Public Hospital Unions, came into force. As of November 2012, a total of 87 Public Hospital Unions were established in 81 provinces, and the

[19] Of course, there were problems in this system concerning the accomplishment of the aims of the law that cover all Turkey.

[20] K. Pala, *Türkiye İçin Nasıl Bir Sağlık Reformu*, Bursa, 2007, p.16.

[21] Family Medicine Law No. 5258; O. C. Cakiroglu and A. K. H. Seren, "The Transformation of Primary Healthcare Services in Turkey: Family Medicine Model", *International Journal of Caring Sciences*, 9(2), September-December 2016, pp.1129-1133; E. D Güneş. and H. Yaman, "Transition to Family Practice in Turkey", *Journal of Continuing Education in the Health Professions* 28(2), March 2008, pp.106-112.

process of transforming public hospitals into “administrative and financial autonomous enterprises” started.

With the component of "health enterprises with administrative and financial autonomy" of the HTP, the aim is privatize the public hospitals and a structural step was taken towards the withdrawal of the Ministry of Health from its roles and responsibilities in the provision of healthcare services. This component of the HTP is the concretized expression of the Ministry of Heath's withdrawal from health service provision and taking on a planning and supervisory role as required by the neoliberal health policies of the period.

New free-market measures were introduced to promote private health institutions beside the transformation of state-owned and state-financed hospitals into independent business enterprises. The process of transforming public hospitals into autonomous enterprises continues but is not completed yet. The process of commodification of health care accelerated with the HTP.[22]

2.3. Public-Private Partnership in Health: City Hospitals

With the HTP especially market-oriented activities in health services have become the main targets. In this regard, practices such as public-private partnerships in health services, the provision of public services by the private sector, the administrative and financial autonomy of health institutions, as well as the contracted employment and family medicine constitute the regulations for privatization.

The Public-Private Partnership (PPP) method, based on the partnership of the public and private sectors in the health sector, has started to be applied in the Turkish health sector. PPP is a method of privatization creating new market opportunities and its purpose is not public benefit. Hospitals operating in the context of PPP deliver private and profit seeking services that erode the system of healthcare.[23]

Among the most common applications of the *public-private* partnership model in Turkey, large-scale hospital projects have been established under the name of "city hospitals". There are lots of problems related to “City Hospitals” in Turkey, out of which the major ones are; a) The method of financing (extremely high cost for the public, payment difficulties faced by public hospitals to be moved, ways to be pursued in relation to treasury guarantee and cases like bankruptcy), b) The site selection (opening of farmland to development and constructions on sites under the threat of floods), c) Problems of physical access resulting from the closure of hospitals located at city centres (geographical/economic accessibility), d) The status of sites to be vacated by public hospitals moving elsewhere (their transfer to contracting companies is at issue), e) Concessions for the delivery of both health and support services in public hospitals to be moved, and f) Issues related to the employment and rights of health workers[24].

2.4. Transition to premium-based compulsory health coverage system

In this process, the premium regime in the financing of health services was expanded, and the financial responsibility of health expenditures was transferred to the society to a large extent. General Health Insurance (GSS) is included in the Social Insurance and General Health Insurance Law (SSGSS) numbered 5510. This law has entered into force as of 1.1.2012 to cover the entire population. Social security and health care financing model in Turkey with this Act has been

[22] E. Cevahir, p. 99.
[23] Pala K., Ö. Erbaş, E. Bilaloğlu, B. İlhan, M. R. Tükel, and S. Adıyaman, “Public Private Partnership in Health Care Case of Turkey”, *World Medical Journal*, 64(4), 2018, pp. 44–48.
[24] K. Pala et al. 2018, p. 47.

ammended. In addition to the state's contribution to the General Health Insurance, healthcare expenses are covered mainly by health premiums taken over from society. The premium-based compulsory health coverage system has been expanded with HTP to all. Everybody could now access health services by paying premiums, including the green card holders[25].

Although the General Health Insurance has been brought to the agenda with the claim of providing health coverage and justice in financing for the entire population, the basic logic is to separate health services and financing, to charge the users through premiums and to keep the basic coverage package narrow and citizens to make additional payments for services or private right. [26]

By separating the provision and financing of health services with the GSS model, the system is built on the service procurement logic. A new status has emerged, where the profitability area of the capital is expanded and the private health sector has developed significantly, along with a cycle in which public resources are transferred to the private health sector with the provision of services from private hospitals with the GSS system.

In fact the informal economy is much more extended in Turkey than in any other European country[27]. The rate of employees out of social security coverage is nearly 35% and in the rural areas it is nearly 85%, and most of them women, according to official statistics in 2018.[28] In general the social security system covers the formal jobs and the premiums are paid by the employees and employers. Registered self-employees and the others that work in informal sector as a worker or a self-employee have to pay their own premiums. Also unregistered unemployed have to pay their own premiums. So most of the workers and self employees in informal sector and unregistered unemployed could not pay their premiums and could not get health services.

Also *additional* payments are charged besides the premiums. While the insured people did not have to pay any fees during public health service usage before the HTP, now, with the HTP, public health services have to be charged for participation payments beside the premiums.

Before the GSS came into force, insured persons received services from Health Centres and Public Hospitals without paying any extra examination fee. After the GSS came into force, primary care (family medicine) and public health services provided by public hospitals started to be charged under the name of "examination participation share" and "prescription contribution fee". These extra fees which are called contribution shares, actually represent the concrete situation of the privatization of public health services through pricing.

3. Social Security Coverage in Turkey

According to the Turkish Social Security Institution everyone living in Turkey has health insurance under the General Health Insurance or the Social Insurance Institution. The population not covered by health insurance is not declared by the institution directly. However, there are some people out of the health insurance coverage, who are self-employed (and their dependents) and have to pay their own premiums under the general health insurance, but they cannot pay. Those who could not pay the premiums and are not covered by health insurance could have been calculated by

[25] Green card was the health insurance of poor people outside the social security system who benefited from health services without paying premiums through the General Health Insurance Act.

[26] Bağımsız Sosyal Bilimciler, *2008 Kavşağında Türkiye, Siyaset, İktisat ve Toplum*, Yordam Kitap, 1. Baskı, İstanbul, 2008, p. 228.

[27] The term "informal employment" is generally used in Turkey to denote the employment of workers in the informal economy as well as employment conditions in that sector. It manifests itself in the form of unregistered workers whose presence in the economy is not declared or only partially declared to the public institutions concerned, as a result of which legal obligations such as the payment of workers' (and employers'), taxes and social security contributions are not fulfilled. Dereli T., "Informal Employment in Turkey", *Sosyal Siyaset Konferansları Dergisi*, 53 (1), 2007, p. 66-82.

[28] TÜİK, İşgücü İstatistikleri Ekim 2018, www.tuik.gov.tr, accessed March 2019.

using the data published on the Social Security Institution Monthly Statistics Bulletins. However, the number of premium debtors is no longer disclosed in the Social Security Institution Monthly Statistics Bulletins (both recent and former ones).

According to the official data of the Turkish Social Security Institution Monthly Statistics Bulletins, published by of the Turkish Medical Association in 2013, there are 5 million people who are not paying their premium debts (Self Employed and General Health Insurance premiums are paid by the ensured) and 1.5 million people not included in the General Health Insurance[29]. In addition, considering the dependent population of the unensured, at least 10% of the population was estimated to be outside the scope of health insurance in 2013. According to researches conducted by Hacettepe University in 2013 and in 2018, 10.5%, and, respectively, 8.8% of the female population is not covered by any kind of health insurance and, also in 2018, 11.3% of the female population is not covered by the General Health Insurance.[30]

According to a statement of the President of Social Security Institution on 28 March 2018 at a TV program, 6.5 million people (8% of the population) have premium debts.[31]

The General Health Insurance is a universal health insurance system but it only covers those who pay their insurance premiums.[32] In 2018, the rate of people lacking access to health insurance was of at least 10% and these people could not reach to health care services.[33] In 2020, at least 10·% of the population is estimated to be outside the scope of health insurance, considering also the dependents of premium debtors.

3.1. The public health insurance scheme does not cover all types of services

In addition, the public health insurance scheme does not cover all types of services: some types of services and medicines are excluded. Not only so-called lifestyle medicines such as medicines for losing weight or for quitting smoking but also medicines such as SMA (spinal muscular atrophy) pills are excluded.[34] Dental care, prescription drugs and optical glasses are only *partially* covered. Plastic surgery is excluded (Law No. 5510). As a consequence, unmet needs among patients who require exempt medicines or services but cannot afford them, is an important problem. Health inequalities between the rich and the poor, men and women, educated and illiterate, urban and rural areas, West and East already existed before the healthcare reforms and continue to

[29] Türk Tabipleri Birliği (Turkish Medical Association), *Genel Sağlık Sigortası: Ne Dediler, Ne Oldu*, 2018, p.9.

[30] Hacettepe University Institute of Population Studies, *2013 Turkey Demographic and Health Survey*, Ankara, Turkey, 2014; Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey*, Ankara, Turkey, 2019.

[31] Sosyal Güvenlik Kurumu (Social Security Institution) , (2018), "Sosyal Güvenlik Kurum Başkanı Dr. Mehmet Selim Bağlı'nın NTV Canlı Yayın Konuşma Metni", http://www.sgk.gov.tr/wps/wcm/connect/135f4247-7efb-4eee-b04e-e83e43627d43/SGK+Başkanı+Mehmet+Selim+Bağlı+Ntv.pdf?MOD=AJPERES, accessed February 2019; Cumhuriyet Gazetesi (Cumhuriyet Newspaper) (2018), "İşsiz yurttaşa GSS 'cezası': 6.4 milyon borçlu var" http://www.cumhuriyet.com.tr/haber/turkiye/1034219/issiz_yurttasa_GSS__cezasi___6.4_milyon_borclu_var.html#, accessed February 2019; Birgün Gazetesi (Birgün Newspaper), (2018), "Milyonlarca kişi prim borcunu ödeyemiyor" https://www.birgun.net/haber-detay/milyonlarca-kisi-prim-borcunu-odeyemiyor-221560.html, accessed February 2019.

[32] R. Ucku et al., "Turkey" in *Comparative Health Systems*, J. Johnson, C. Stoskopf and L. Shi (eds), 2018, pp. 281-295.

[33] See Sosyal Güvenlik Kurumu (Social Security Institution) (2018) "Sosyal Güvenlik Kurum Başkanı Dr. Mehmet Selim Bağlı'nın NTV Canlı Yayın Konuşma Metni".

[34] See Turkish Pharmacists' Association (2018) "Bedeli Ödenecek İlaçlar Listesinde (EK-4/A) pasiflenecek ilaçlar"; Turkish Medical Association (2018) "Yaşamsal önemdeki ilaç ve malzemelerin temini için gerekli önlemler bir an önce alınmalıdır"; Sütlaş M. (2013) "Ödeme kapsamı dışındaki ilaçlar ve sağlık hakkı", Bianet, https://m.bianet.org/bianet/saglik/149149-odeme-kapsami-disindaki-ilaclar-ve-saglik-hakki, accessed February 2019; G. Yenimahalleli Yaşar and E. Uğurluoğlu, "Can Turkey's General Health Insurance System Achieve Universal Coverage?", *International Journal of Health Planning and Management*, 26(3), 2011, pp.282-295.

exist.[35] Apparently, the reforms did neither eliminate inequalities in access to health care, nor did they facilitate access to health care services.

3.2. The private health sector has increased in the process

The private health sector has increased its range over recent years.[36] With the HTP, the Social Security Institution has started to purchase services from private health institutions. Patients who apply to private health institutions, make additional payments apart from the payment of premiums to the Social Security Institution. The recent decision by the Council of Ministers to increase the maximum rate of additional payments that private hospitals are allowed to charge patients, from 30% to 200% percent of SGK price limits for services in private hospitals, emphasizes the political tendency of liberalization of health services.[37]

While the share of private hospitals in the health expenditures of the Social Security Institution was 5.2% in 2002, this rate has increased over the years and reached 18% in 2019[38]. With GSS, services without referral started to be provided by private hospitals. The process of encouraging the private sector and the services provided by the private sector under the Social Security Institution [39] has led to an increase of the number of Private Hospitals from 271 in 2002 to 577, with an increase of 212% in 2018.

3.3. The increasing health expenditures

Private financing options in health care cannot be recommended at all, because they cause inequalities in access to health services. On the other hand, there are two types of public finance models, but the model that should be preferred from public finance models is the tax-budget model.[40] There are two reasons for this: 1) Since it is possible to apply taxes to increasing income in an increasing rate, financing the health services with tax improves the egalitarian character of the financing health. Thus, because of the proportion of contributions to the fund in the premium system (although the contribution of high-income to the fund will rise in absolute terms) is the same rate for all, the egalitarian character of the premium based models is limited compared to those financed by tax. 2) Funds created for a single purpose (health insurance fund established to finance health care) will increase the use of health services unnecessarily, as well as their expenditures. In 2002, the total health expenditure of the Social Security Institution was 8 billion TL and this amount increased 11 times in 2018 and reached 91 billion TL.[41] In 2002, the health expenditure per capita amounted to PPP USD 460, which increased by 2.6 times in 2018 and reached PPP USD

[35] See Hacettepe University Institute of Population Studies, 2009; Hacettepe University Institute of Population Studies, 2014; N. Dedeoğlu "Health and social inequalities in Turkey", *Social Science & Medicine*, 31(3), 1990, pp.387-392; K. Pala, "Neoliberal health reforms in Turkey", *Pre Conference Workshop of IAHPE in Collaboration with TMA*, İstanbul, Turkey, January 14-15 2017; O. Hamzaoglu et al., "Can Health Inequalities Be Reduced through Healthcare Reforms? Turkey's Experience", *International Medical Journal*, 21(1), February 2014, pp.73-76; M. Tatar et al., "Turkey Health system review", *Health System in Transition*, 13(6), 2011, 1-186; F. Zeren et al. "Regional health care inequality in Turkey: Spatial exploratory analysis.", *İnönü University International Journal of Social Sciences* (INIJOSS) 1, 2012, p.2-20; I. Ergin and A. E. Kunst, "Regional inequalities in self-rated health and disability in younger and older generations in Turkey: the contribution of wealth and education", *BMC Public Health*, 15(1), 2015, p.987.

[36] M. Tatar et al., 2011.

[37] E. Cevahir, 2016, p.99.

[38] SGK, Mart 2013 Aylık Temel Göstergeler, www.sgk.gov.tr, accessed 01.06.2013; SGK, Nisan 2020 Aylık Temel Göstergeler, www.sgk.gov.tr, accessed 19.08.2020.

[39] TUİK, http://www.tuik.gov.tr/PreTablo.do?alt_id=1095, accessed 19.08.2020.

[40] İ. Belek, *Sağlıkta Dönüşüm*, İstanbul, 2012, p.80.

[41] SGK (2018) 2018 İstatistik Yıllığı, www.sgk.gov.tr, accessed August 2020.

1.223.[42] It is expected that health premium rates will increase in order to meet increasing health expenditures. For example with the increasing health expenditures in Germany, the insurance premium rate increased from 8.4·% in 1960 to 15.5·% in 2012.[43]

While Turkish health care transformation has been presented as a good example by international organisations, there are still serious challenges in health care that are inadequately addressed by them. Some of the manifestations of inequalities in health care are visible in health indicators and access to health care services.[44]

4. Instead of conclusions

Since the 1980s, with a neo-liberal transformation process, the marketisation, commercialisation and privatisation of public services have come to agenda in Turkey the same as all around the world. In this context, there has been a paradigm shift in public health services in Turkey. First of all, with the 1982 Constitution after coup d'état 12 September 1980, the defining roles and responsibilities of the state in health and health services, namely to provide them by itself as an *obligation,* ceased, and "planning", "controlling" and "policymaking" roles according to the new model of marketisation have been adopted. Efforts to implement this paradigm transformation have been started then, but the radical transformation of the health system was carried out by the Health Transformation Program (HTP) launched in 2003.

In this respect, primary health care services have shifted from the public service delivery in the health centres to the family medicine system, and the state withdrew from the role of financing primary health care delivery by transferring its responsibility in primary care to contracted family physicians. Also, considering the contracted work of family physicians, who have to meet all the expenses of the Family Health Center they work in by themselves, the Family Health Centers, where primary health care services are provided, have turned into "physician enterprises".

The structural transformation in public hospital services started to be implemented with the Public Hospital Unions model, which was put into practice in line with "health enterprises with administrative and financial autonomy", which is one of the main objectives of the Health Transformation Program. With the transition to Public Hospitals Unions, a structural step was taken towards the withdrawal of the Ministry of Health from its roles and responsibilities in the provision of healthcare services and thus it turned into a "planning, supervisory and policy-making" Ministry. With the Public Hospital Unions, the understanding of conducting public hospital health services has been replaced by "public" hospitals operating in the "market conditions" with the principles of "business administration".

In this process, the premium regime in the financing of health services was expanded and the financial responsibility of health expenditures was transferred to the society to a large extent. With the GSS, the segments that benefited from health services without paying health premium - civil servants, green card holders - were subjected to the premium regime. Considering those who benefited from health services without paying premiums in the previous health system and the "participation shares" paid during the health service utilization phase, it is obvious that this transformation has a "market oriented" transformation content.

[42] OECD (2019) Health Data 2019, www.oecd.org, accessed August 2020.
[43] R. Busse and A. Riesberg, *Health Care Systems in Transition: Germany*, WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark, 2014, p.15; D. Green et al. *Healthcare Systems: Germany*, 2012, p. 5.
[44] A. Buğra et al. *The Case Study on Income and Social Inequalities in Turkey*, UNDP, 2016, p. 27.

In addition, the population coverage of GSS is also a controversial issue. It is not realistic to cover practically the entire population, as healthcare utilization through GSS is associated with premium payment. But because of the prevalence of informal employment and high unemployment rates in Turkey, this model which leans on regular premium payment does not appear to be a viable option to collect premiums. As of 2020, the rate of premium debtors is approximately 10%. This fact, which turns into the expression of millions of people being deprived of health insurance due to premium debts (10% of the population), shows that the claim that GSS covers the whole society is just rhetoric.

By separating the provision and financing of health services with the GSS model, the system is built on the service procurement logic. The GSS system is based on financing healthcare services through contracts with private healthcare service providers. This, added to the health services that have been commodified with the HTP, and thus the "health market", has expanded. Transferring public resources to the private health sector with the purchase of services from private hospitals, a new status has emerged, where the profitability of the capital has increased, and the private health sector developed significantly. Also health expenditures increased significantly during this period.

In this process, primary health care services were transformed into "physician enterprises" with the family medicine system, hospitals of the Ministry of Health into "public health enterprises" and patients into "customers". While public health services undergo the process of "marketization" and "privatization" in this way, a capital accumulation mechanism based on the transfer of public resources to the private sector has been created, with the opportunity to benefit from private hospitals without referrals within the scope of the GSS.

5. References

1. Aktan Ö. et al. (2014) “Health-care reform in Turkey: far from perfect”, *The Lancet*, 383(9911), January 04, 2014, p.25-26
2. Ataay, F., “Kamu-Özel İşbirliği Modeli Üzerine Eleştirel Bir Değerlendirme: Sağlık Sektörü Örneği”, in V. Erat et al. eds, *Quo Vadis: Kamu Yönetimi*, Ankara: Nika Y., 2018, pp.403-416.
3. Ataay, F., “Sağlık Reformu ve Yurttaşlık Hakları”, *Amme İdaresi Dergisi*, 41(3), September 2008, pp.169-184.
4. Bağımsız Sosyal Bilimciler, *2008 Kavşağında Türkiye, Siyaset, İktisat ve Toplum*, Yordam Kitap, 1. Baskı, İstanbul, 2008.
5. Bazac, A., “Epistemology of Empirical Research: The Case of the Consequences of the Romanian neo-liberal ‘Healthcare’ Law”, *Journal of Contemporary Central and Eastern Europe*, 26, 2018, pp. 225-245.
6. Belek İ., *Sağlıkta Dönüşüm*, İstanbul, 2012.
7. Birgün Gazetesi (Birgün Newspaper) (2018) “Milyonlarca kişi prim borcunu ödeyemiyor”, [https://www.birgun.net/haber-detay/milyonlarca-kisi-prim-borcunu-odeyemiyor-221560.html], Accessed February 2019.
8. Buğra A. et al., *The Case Study on Income and Social Inequalities in Turkey*, UNDP, 2016.
9. Buğra, A., “Two Lives of Developmentalism: A Polanyian View from Turkey” in *Development as a Battlefield*, International Development Policy Series No.8, Geneva, Boston: Graduate Institute Publications, Brill-Nijhoff, 2017, pp. 61-80.
10. Busse R. and Riesberg A., *Health Care Systems in Transition: Germany*, WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark, 2014.
11. Cakiroglu O. C. and Seren A. K. H., “The Transformation of Primary Healthcare Services in Turkey: Family Medicine Model”, *International Journal of Caring Sciences*, 9(2), September-December 2016, pp.1129-1133

12. Cevahir E., *Transformation of Health Care System in Turkey: Social Reflection Examples* (Türkiye'de Sağlık Sisteminin Dönüşümü: Toplumsal Yansıma Örnekleri), Kibele Yayınları, İstanbul, 2016.
13. Civaner M., "Health-care reform in Turkey: far from perfect", *The Lancet*, 383(9911), January 04 2014, p.26
14. Cumhuriyet Gazetesi (Cumhuriyet Newspaper) (2018) "İşsiz yurttaşa GSS 'cezası': 6.4 milyon borçlu var" [http://www.cumhuriyet.com.tr/haber/turkiye/1034219/issiz_yurttasa_GSS__cezasi___6.4_milyon_borclu_var.html#], Accessed February 2019.
15. Dedeoğlu N., "Health and social inequalities in Turkey", *Social Science & Medicine*, 31(3), 1990, pp. 387-392.
16. Dereli T., "Informal Employment in Turkey", *Sosyal Siyaset Konferansları Dergisi*, 53(1), 2007, pp. 66-82
17. Ergin I. and Kunst A. E., "Regional inequalities in self-rated health and disability in younger and older generations in Turkey: the contribution of wealth and education", *BMC Public Health*, 2015, 15(1), p.987
18. Green D. et al. *Healthcare Systems: Germany*, 2012.
19. Güneş E. D. and Yaman H. "Transition to Family Practice in Turkey", *Journal of Continuing Education in the Health Professions*, 28(2), March 2008, pp.106-112
20. Hacettepe University Institute of Population Studies, *2008 Turkey Demographic and Health Survey*, Ankara, Turkey, 2009.
21. Hacettepe University Institute of Population Studies, *2013 Turkey Demographic and Health Survey*, Ankara, Turkey, 2014
22. Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey*, Ankara, Turkey, 2019.
23. Hamzaoglu O. et al., "Can Health Inequalities Be Reduced through Healthcare Reforms? Turkey's Experience", *International Medical Journal*, 21(1), February 2014, pp. 73-76
24. Navarro V. *Medicine Under Capitalism*, Prodist, New York, 1976.
25. OECD, Health Data 2019, [www.oecd.org] [Accessed August 2020]
26. OECD, *Reviews of Health Care Quality: Turkey 2014: Raising Standards*, OECD Publishing, 2014
27. Öktem Z. G. and Çakar M. A., "What have health care reforms achieved in Turkey? An appraisal of the Health Transformation Programme", *Health Policy*, 119(9), September 2015, pp.1153-1163
28. Pala K., "Neoliberal health reforms in Turkey", Pre Conference Workshop of IAHPE in Collaboration with TMA, İstanbul, Turkey, January 14-15 2017.
29. Pala K., Ö. Erbaş, E. Bilaloğlu, B. İlhan, M. R. Tükel, and S. Adıyaman, "Public Private Partnership in Health Care Case of Turkey ," *World Medical Journal*, 64(4), 2018, pp. 44–48,
30. Pala, K., *Türkiye İçin Nasıl Bir Sağlık Reformu*, Bursa, 2007.
31. Sakellariou D. and Rotarou E. S., "The effects of neoliberal policies on access to healthcare for people with disabilities", *International Journal of Equity Health*, 16(1), 2017, pp.1-8
32. SGK, 2018 İstatistik Yıllığı, www.sgk.gov.tr access: August 2020
33. SGK, Mart 2013, Aylık Temel Göstergeler, www.sgk.gov.tr, accessed 01.06.2013
34. SGK, Nisan 2020, Aylık Temel Göstergeler, www.sgk.gov.tr, accessed 19.08.2020
35. Sosyal Güvenlik Kurumu (Turkey Social Security Institution) (2018) "Sosyal Güvenlik Kurum Başkanı Dr. Mehmet Selim Bağlı'nın NTV Canlı Yayın Konuşma Metni", [http://www.sgk.gov.tr/wps/wcm/connect/135f4247-7efb-4eee-b04e-e83e43627d43/SGK+Başkanı+Mehmet+Selim+Bağlı+Ntv.pdf?MOD=AJPERES], Accessed February 2019.
36. Sütlaş M. (2013) "Ödeme kapsamı dışındaki ilaçlar ve sağlık hakkı", *Bianet*, [https://m.bianet.org/bianet/saglik/149149-odeme-kapsami-disindaki-ilaclar-ve-saglik-hakki], Accessed February 2019.
37. Sütlaş M., "Health Transformation Program and the 2012 Turkey Health Panorama", Heinrich Böll Stiftung Türkei, 2012, pp.46-47, [https://tr.boell.org/de/2014/06/16/health-transformation-program-and-2012-turkey-health-panorama], Accessed February 2019.
38. Tatar M. et al., "Turkey Health system review", *Health System in Transition*,13(6), 2011, 1-186.

39. TUİK, İşgücü İstatistikleri Ekim 2018, [www.tuik.gov.tr], Accessed March 2019.
40. Türk Tabipleri Birliği (Turkish Medical Association), *Genel Sağlık Sigortası: Ne Dediler, Ne Oldu?*, 2018.
41. Turkish Medical Association (2018) "Yaşamsal önemdeki ilaç ve malzemelerin temini için gerekli önlemler bir an önce alınmalıdır" [http://www.ttb.org.tr/haber_goster.php?Guid=13c93d00-c63f-11e8-829a-3584f952ad6f], Accessed February 2019.
42. Turkish Pharmacists' Association (2018) "Bedeli Ödenecek İlaçlar Listesinde (EK-4/A) pasiflenecek ilaçlar" [https://www.teb.org.tr/news/7921/SGK%EF%BF%BD%EF%BF%BDnın-31072018-Tarihinde-Pasife-Alacağı-İlaçlar-Listesi-Hakkında], Accessed February 2019.
43. Ucku R. et al. "Turkey", in J. Johnson, C. Stoskopf and L. Shi (eds) *Comparative Health Systems*, 2018, pp. 281-295.
44. WHO, *Successful Health System Reforms: The Case of Turkey*, WHO Regional Office for Europe Scherfigsvej 8 DK-2100 Copenhagen, Denmark, 2012
45. Yeldan, E., "Sağlıkta Dönüşüm Programı ve Gerçekler", 12 Ocak 2005, [http://www.bilkent.edu.tr/~yeldane/Yeldan07_12Ocak05.pdf], Accessed November 2012.
46. Yenimahalleli Yaşar G. and Uğurluoğlu E., "Can Turkey's General Health Insurance System Achieve Universal Coverage?", *International Journal of Health Planning and Management* 26(3), 2011, pp. 282-295.
47. Yılmaz V., "Changing origins of inequalities in access to health care services in Turkey: From occupational status to income", *New Perspectives on Turkey*, 48, 2013, pp. 55-77.
48. Yücesan-Özdemir, G. and Özdemir, A. M., *Sermaye'nin Adaleti*, Ankara, Dipnot Yayınları, 1. Baskı, 2008.
49. Zeren F. et al., "Regional health care inequality in Turkey: Spatial exploratory analysis", *İnönü University International Journal of Social Sciences,* (INIJOSS), 2012, pp. 2-20.