

Changing origins of inequalities in access to health care services in Turkey: From occupational status to income

Volkan Yılmaz

Abstract

Health care reforms have always been critical political arenas within which the parameters of citizens' access to health care services and thus the new terms of social bargain that backs social policies are negotiated. Despite the relative success of Turkey in establishing public health insurance schemes and developing a public capacity for health care service delivery since the late 1940s, Turkey's health care system has largely failed to institute equality of access to health care services. With the promise of abolishing the inequalities, the ruling Justice and Development Party (AKP) launched Turkey's Health Transformation Program in 2003. Since then, Turkey's health care system has been undergoing a significant transformation. On the one hand, with the unification of all public health insurance schemes under a compulsory universal health insurance scheme and the equalization of benefit packages for all publicly insured, the program has succeeded in abolishing the occupational status-based inequalities in access to health care services. On the other, this article suggests that the program has changed the main origin of inequalities in service access from occupational status to income. As the country suffers from an uneven distribution of income, it is argued that these income-based inequalities in access pose a significant threat to the realization of the social citizenship ideal in Turkey.

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Access to health care services remains one of the key issues through which the terms of the social bargain have been negotiated in contemporary societies. Inequalities in access to health care are prevalent in many health care systems yet their forms and origins may vary. This article specifically concentrates on Turkey's health care system as a single country case and examines the inequalities it engenders.

Turkey's health care system has been undergoing a significant transformation since the Justice and Development Party (*Adalet ve Kalkınma Partisi*, AKP) government launched its Health Transformation Program (HTP) in 2003. Since then, the reform has paved the way to the restructuring of health care finance, provision and service regulation in Turkey. The main aim of this article is to analyze how and to what extent the program has influenced inequalities in access to health care services, and it focuses exclusively on two origins of such inequalities; those deriving from the occupational status positions created by public health insurance legislation and those originating in service users' relative positions within the country's income distribution.

The impacts of the reform on access to health care services in Turkey has already received considerable scholarly attention. Some scholars have suggested that the impact has been overwhelmingly egalitarian as the reform has ended the occupational status-based inequalities in access to health care and facilitated citizens' access to health care services.¹ In contrast, other scholars have argued that the reform's pro-market aspects and reliance upon a social insurance-based financing model pose significant obstacles to the realization of equality in access.²

1 See, Enis Bariş et al., "Healthcare in Turkey: From Laggard to Leader," *British Medical Journal* 342, c7456 (2011); Oğuz Karadeniz, "Annual National Report 2009-Pensions, Health and Long-term Care," in *Analytical Support on the Socio-Economic Impact of Social Protection Systems* (European Commission DG Employment, Social Affairs and Equal Opportunities, 2009); Tuncay Teksöz, Yalçın Kaya and Kerem Helvacıoğlu, "Sağlık Reformunun Sonuçları İtibarıyla Değerlendirmesi" (Türkiye Ekonomi Politikaları Araştırma Vakfı, 2009); Tuba I. Agartan, "Turkish Health System in Transition: Historical Background and Reform Experience," (PhD Dissertation, State University of New York, 2008); Tuba I. Agartan, "Turkish Health Policy in a Globalizing World: The Case of 'Transformation of Health' Program," (paper presented at the *ISA Research Committee 19th Annual Academic Conference*, Florence, 2007); Çağlar Keyder, "Giriş," in *Avrupa'da ve Türkiye'de Sağlık Politikaları*, eds. Ç. Keyder et al. (İstanbul: İletişim, 2007).

2 See, Tuba I. Agartan, "Marketization and Universalism: Crafting the Right Balance in the Turkish Healthcare System," *Sociology* 60, no. 4 (2012): 456-471; Gülbiye Yenimahalleli Yaşar and Ece Uğurluoğlu, "Can Turkey's General Health Insurance System Achieve Universal Coverage?," *International Journal of Health Planning and Management* 26, no. 3 (2011): 282-295; Gülbiye Yenimahalleli

While all these accounts successfully explore particular impacts of the reform on access, they hardly offer a comprehensive analysis of the systematic change which has occurred in the conditions for citizens' access to health care services. This article addresses this gap, offering a comprehensive account of the impact of the reform on the access inequalities that prevailed before the reform and the seeds of the new inequalities which the reform has planted. The article argues that the reform has resulted in a shift in the main origin of inequalities in access to health care from occupational status to income.

The article is organized as follows: The first part locates Turkey's pre-reform health care system within a comparative framework and explains its unique features. The second discusses three major inequalities in access to health care in the pre-reform system. The third part offers both an account of the positive impacts of the HTP on access to health care and an analysis of new manifestations of inequalities in access to services that the program engenders. The last part examines the overall impact on access of current health care reform and discusses the reform's implications for the future of the health care system, as well as a prospective social bargain that could support social policies in Turkey.

Turkey's health system within a comparative framework

In most countries today, health care services remain both a citizenship right and a commodity.³ On the one hand, with the ratification of World Trade Organization's General Agreement on Trade in Services (GATS) and other regional conventions such as the European Directive on Services in the Internal Market, it has become clear that health care services are in the process of becoming global commodities, through medical tourism and freedom of movement for medical doctors.⁴ On the other,

Yaşar, "Review: 'Health Transformation Programme' in Turkey: An Assessment", *International Journal of Health Planning and Management* 26, no. 3 (2011): 110-133; Mustafa Sönmez, *Paran Kadar Sağlık: Türkiye'de Sağlık Ticarileşmesi* (İstanbul: Yordam Kitap, 2011); Türk Tabipleri Birliği, "AKP Sağlık Politikası: Yalanlar ve Gerçekler," *Bağımsız İletişim Ağı (BIANET)*, May 25, 2011; Murat Civaner, "Transforming Our Health by Privatisation-Response to Baris et al.," *British Medical Journal* (2011); Reyhan Uçku and Ömur Çınar Elçi, "Turkey," in *Comparative Health Systems: Global Perspectives*, ed. James A. Johnson and Carleen H. Stoskopf (Boston, Toronto, London and Singapore: Johns and Bartlett Publishers, 2010); Nazan Üstündağ and Çağrı Yoltar, "Türkiye'de Sağlık Sisteminin Dönüşümü: Bir Devlet Etnografisi," in *Avrupa'da ve Türkiye'de Sağlık Politikaları (Health Policies in Europe and in Turkey)*, eds. Çağlar Keyder et al. (İstanbul: İletişim, 2007); Kayıhan Pala, "Türkiye Sağlık Sistemi Nereye Gidiyor?," *Toplum ve Hekim* 22, no. 1-2 (2007).

- 3 A commodity is defined as a thing that is being bought and sold by means of exchange, which satisfies human wants in one way or another. See, Karl Marx, *Capital* (Oxford: Oxford University Press, 2008): 13-50.
- 4 See, Robert H. Blank and Viola Burau, *Comparative Health Policy* (Hampshire: Palgrave Macmillan, 2010), 8; Sarah Sexton, "Trading Healthcare Away: The WTO's General Agreement on Trade in Services,"

national health care systems continue to regulate markets for health care services, and some of these systems still put serious restrictions on market forces with the aim of securing their citizens' access to health care services as a citizenship right.

Making access to health care services a citizenship right in fact implies the decommodification of health care services. Decommodification in general refers to "the degree to which individuals, or families, can uphold a socially acceptable standard of living independently of market participation."⁵ Applying Esping-Andersen's approach to the domain of health care, Bambra coins the term "decommodification of health care." This refers to "the extent to which an individuals' access to health care is dependent upon their market position and the extent to which a country's provision of health is independent from the market."⁶

How and to what extent health care services are decommodified depends upon the way a health care system of a country articulates health care finance to access to health services. In other words, the health care finance model is the strongest determinant of access in any health care system. Four main sources of funding for health care services are listed in the literature. These sources are general taxation, social insurance, private insurance and direct payments by users.⁷ While the majority of countries rely on a combination of these sources, one source of funding is usually dominant in a given health care system.⁸ The dominance of one or another of these funding sources gives a health care system its general characteristic.

The literature on health care system typologies is rich.⁹ For the purposes of this article, Ann Wall's tripartite typology is useful as it ad-

es (GATS)," in *Restructuring Health Services: Changing Contexts & Comparative Perspectives*, ed. Kasturi Sen (London and New York: Zed Books, 2003), 39-40.

5 Gösta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Cambridge and Princeton: Polity Press and Princeton University Press, 1990), 37.

6 Clare Bambra, "Worlds of Welfare and the Health Care Discrepancy," *Social Policy & Society* 4, no. 1 (2005), 33.

7 Robert H. Blank and Viola Burau, *Comparative Health Policy* (Hampshire: Palgrave Macmillan, 2010), 13; Charles Normand, "Health Insurance: A Solution to the Financing Gap?," in *Marketizing Education and Health in Developing Countries: Miracle or Mirage?*, ed. Christopher Colclough (Oxford: Clarendon Press, 1997), 205.

8 Normand, "Health Insurance," 205.

9 See, Claus Wendt et al., "Healthcare System Types: A Conceptual Framework for Comparison," *Social Policy & Administration* 43, no. 1 (2009): 70-90; Patrick Hassenteufel and Bruno Palier, "Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems," *Social Policy & Administration* 41, no. 6 (2007): 574-596; Viola Burau and Robert H. Blank "Comparing Health Policy: An Assessment of Typologies of Health Systems", *Journal of Comparative Policy Analysis*, 8, no. 1 (2006): 63-76; Heinz Rothgang et al., "The Changing Role of the State in Healthcare Systems," *European Review* 13, no. 1 (2005): 187-212; Clare Bambra, "Health Status and the Worlds of Welfare," *Social Policy and Society* 5, no. 1 (2005): 53-62.

dresses different articulations of health care finance and access to health care services. Wall suggests three Weberian ideal-types, namely the Beveridge, Bismarckian and modified market models.¹⁰

In Wall's typology, the Beveridge model symbolizes funding of health care services out of general taxation and the provision of health care services free at the point of need for all citizens. This model results in a high level of decommodification of health care services. The Beveridge model leaves no room for income to become a source of differentiation among citizens in obtaining access to health care services. Even though some elements of Britain's National Health Service (NHS) have been undergoing transformation in the last couple of decades, it is generally accepted as the example most closely resembling this model.

The second ideal-type in Wall's typology is the Bismarckian model. This model relies on compulsory social health insurance and recognizes access to health care as a social right attached to one's occupational status. In the Bismarckian model, health care expenditures are generally funded out of premiums paid by three parties, namely the employer, the employee and the state. Similar to the Beveridge model, the Bismarckian model also results in a high level of decommodification of health care services. However, it also generates inequalities in access according to occupational status differences among citizens. Germany has been accepted as the closest example of this model.

The last ideal-type in Wall's typology is the modified market model, which implies the dominance of private health insurance in health care finance. This model recognizes health care services as commodities and health risks as insurable risks. The modified market model links access to health care services to both the capacity and willingness to pay premiums to private health insurance funds and the ability to choose the "right" insurance. Unlike the not-for-profit public health insurance schemes in the Bismarckian model, the modified market model relies upon for-profit private health insurance services. Given that people generally demand health care services and medications when they need them the most, private health insurance funds are structurally in a powerful position vis-à-vis patients. Even the pioneers of the discipline of health economics acknowledged this risk and argued that pure market solutions for health care would end up in "market failure."¹¹ Indeed, the modified market model generally leads to the exclusion of a considerable number of people; those with high per-

10 Ann Wall, "Conclusion," in *Health Care Systems in Liberal Democracies*, ed. Ann Wall (London: Routledge, 1996), 83-84.

11 Kenneth Joseph Arrow, "Uncertainty and the Welfare Economics of Medical Care," *The American Economic Review* 53, no. 5 (1963): 967.

sonal health risks and/or those unable to afford to pay their premiums. In order to compensate for the ills of this model, countries with health systems close to the modified market model generally offer some residual protection from health risks for the very poor. In this model, the level of decommodification of health care is low. Income and good health (for example, lack of genetic diseases) remain the main sources of differentiation among citizens. The health care system in the United States is considered an example close to this model.

Historically, similar to the health care systems in Latin American¹² and Southern European countries,¹³ the health care system in Turkey bore a close resemblance to the Bismarckian model.¹⁴ However, it should be noted that Turkey's health system diverges from the Bismarckian ideal type as social insurance funds in Turkey before the reform were not administered by trade unions autonomously from governments. Up until the current reform, the number of citizens with private health insurance was quite low,¹⁵ and Turkey's health care system relied upon three public insurance schemes—the Social Insurance Institution (*Sosyal Sigortalar Kurumu*, SSK) for formal workers, the Retirement Fund for Civil Servants (*Emekli Sandığı*, ES) and the Pension Fund for the Self Employed (*Esnaf, Sanatkarlar ve Diğer Bağımsız Çalışanlar Sigortalar Kurumu*, BAĞ-KUR)—that combined retirement pensions with health insurance.¹⁶ As the names of these schemes suggest, they were organized along occupational status lines. Until recently, the government did not contribute financially to these schemes; their revenues were collected from employees and employers.

Despite the presence of this formal Bismarckian social security, Turkey's health care system failed to provide universal coverage, mainly due to the prevalence of a high level of informal employment. To address this problem, in the early 1990s, these three schemes were complemented by a new social assistance scheme—known as the green card (*yeşil kart*)—that

12 See, Armando Barrientos and Peter Lloyd-Sherlock, "Reforming Health Insurance in Argentina and Chile," *Health Policy and Planning* 15, no. 4 (2000): 417–423.

13 See, Maurizio Ferrera, "Welfare States and Social Safety Nets in Southern Europe: An Introduction," in *Welfare State Reform in Southern Europe*, ed. Maurizio Ferrera (London: Routledge, 2005); Alberta Andreotti et al., "Does a Southern European Model Exist?," *Journal of Contemporary European Studies* 9, no. 1 (2001); Martin Rhodes, "Southern European Welfare States: Identity, Problems and Prospects for Reform," *South European Society and Politics* 1, no. 3 (1996): 1–22.

14 Ayşe Bugra and Aysen Candas, "Change and Continuity under an Eclectic Social Security Regime: The Case of Turkey," *Middle Eastern Studies* 47, no. 3 (2011), 516.

15 In 2000, approximately 0.4 percent of the population had private health insurance coverage. Please see, Turkish Industrialists' and Businessmen's Association (TÜSİAD), *Charting the Way Forward: Health Care Reform in Turkey* (Istanbul: TÜSİAD Publications, 2005).

16 The SSK was founded in 1946, the ES was established in 1954 and the BAĞ-KUR was founded in 1971.

offered free inpatient health care services for the very poor. As the green card was funded out of the general budget, some scholars argued that its introduction implied the emergence of a Beveridgean component in Turkey's health system.¹⁷ In 2000, expenditure on the green card scheme reached one-fourth of public expenditure on health care services.¹⁸

Given these characteristics, scholars identify Turkey's previous social security system as an eclectic system that included formal social security alongside high levels of informality.¹⁹ Here it is argued that this conceptualization is valid for the pre-reform health care system in Turkey. The next part of the article explores the inequalities in access to health care to which this eclectic health care system gave rise.

Inequalities in access to health care services before the current reform

The inequalities that Turkey's health care system generated before the launch of the Health Transformation Program can be divided into three categories: inequalities among beneficiaries of the three public insurance schemes; inequalities between publicly insured and uninsured sections of society (including green card users and people without insurance); and inequalities arising from informal payments in health care provision. Each of these inequalities is examined in detail below.

Inequalities among beneficiaries of public insurance schemes

The formal Bismarckian elements of Turkey's former health care system were composed of three social insurance schemes, and relied upon a stratification that closely represented the status differences in Turkey's labor market.²⁰ This stratification manifested itself in significant differences among three insurance schemes in terms of their premium rates, benefit packages and the quality of the services they provided for their beneficiaries.²¹ For instance, the system relied upon the direct transfers from the public budget to finance health care services for active civil servants, while active blue collar workers had to pay 5 percent of their wages to the SSK and the active self-employed and farmers had to con-

17 Bengi Demirci, "Transformation in the Organizational and Financial Set-up of the Health Care System in Turkey: Its Repercussions and Similarities with the English Model" (PhD Dissertation, Middle East Technical University 2012), 236.

18 The Ministry of Health of Turkey, *Turkey National Health Accounts 1999-2000* (Ankara: The Ministry of Health of Turkey, Refik Saydam School of Public Health, 2004), 21.

19 Bugra and Candas, "Change and Continuity," 516.

20 Ibid., 518.

21 Agartan, "Turkish Health System"; Agartan, "Turkish Health Policy"; Ayşe Buğra and Çağlar Keyder, "The Turkish Welfare Regime in Transformation," *Journal of European Social Policy* 16, no. 3 (2006): 211-228.

tribute 20 percent of their monthly income to the BAĞ-KUR in order to finance the health care services from which they would benefit.²² Within this stratified structure, it is clear that the state only financed health care services for active civil servants. On the benefit side, civil servants also enjoyed the highest quality health care services provided by the public sector,²³ and they could also be referred to private facilities.²⁴ Workers and the self-employed, however, could only get access to often crowded public hospitals which generally offered low technology health care. In addition, the social insurance-based health care finance strategy had negative implications for the members of BAĞ-KUR, as many were highly indebted to the fund resulting in their being denied access to health care services. For these reasons, before the contemporary reform in health care, members of SSK and the BAĞ-KUR had become highly disillusioned with public health services.

Inequalities between beneficiaries of public insurance schemes and 'outsiders'
Similar to the case in Latin American countries, like Argentina and Chile,²⁵ and the Southern European countries,²⁶ the Bismarckian elements of Turkey's health care system could only offer health insurance coverage to civil servants and formally employed workers,²⁷ resulting in the exclusion of considerable number of citizens from the health care system. In line with the developmentalist aspirations of the period between the end of World War II and the beginning of 1980s, this group of outsiders was expected to disappear as industrial development gained pace and created a high volume of formal jobs.²⁸

Nevertheless, two historical developments undermined this optimistic expectation and resulted in a dramatic increase in the number of outsiders. The first was the decline in formal employment opportunities due to a neoliberal restructuring of Turkey's economy which led to the restriction of state's role as an employer. Secondly, the forced migration of around one million citizens of Kurdish origin during the armed

22 Seher Nur Sulku and Didem Minbay Bernard, *Financial Burden of Health Care Expenditures in Turkey: 2002-2003* (working paper, Agency for Healthcare Research and Quality, 2009), 6-7.

23 Üstündağ and Yoltar, "Türkiye'de Sağlık Sisteminin Dönüşümü," 63-64.

24 Sulku and Bernard, "Financial Burden," 5.

25 See, Barrientos and Lloyd-Sherlock, "Reforming Health Insurance"; and Charles Dannreuther and Jasmine Gideon, "Entitled to Health? Social Protection in Chile's Plan AUGE," *Development and Change* 39, no.5 (2008): 845-864.

26 See, Ferrera, "Welfare States and Social Safety Nets"; Andreotti et al., "Southern European Model"; Rhodes, "Southern European Welfare States."

27 Buğra and Keyder, "Turkish Welfare Regime."

28 Ayşe Buğra and Çağlar Keyder, *New Poverty and Changing Welfare Regime of Turkey* (Ankara: UNDP Turkey, 2003), 17.

conflict between the Turkish Military Forces (TSK) and the Kurdistan Workers' Party (PKK) drastically increased the number of poor people living in the peripheries of metropolitan cities with little hope of finding a position in the formal labor market.

As the number of outsiders gradually became impossible to ignore politically, the green card scheme was introduced. The green card scheme, in its original version, was a social assistance scheme that provided the very poor access to free inpatient services. While the introduction of the green card signified an expansion of the state's role in ensuring access to health care, it did not abolish the inequalities between publicly insured citizens and green card beneficiaries for four reasons: Firstly, the benefit package of the green card was restricted to inpatient services only. Secondly, entitlement to a green card required applicants to undergo stringent means-testing procedures, which contributed to the stigmatization of the poor citizens, and made applications quite lengthy and laborious. The openness of these procedures to political manipulation also led governments to use the green card scheme as a disciplinary mechanism against politically organized poor citizens.²⁹ Thirdly, due to the frequent delays in reimbursement from the government, public hospitals were quite reluctant to provide services for green card users, which created an informal obstacle to access to inpatient services.³⁰ Lastly, green card holders, despite holding the right to access inpatient services, hardly benefited from these services on an equal footing with the publicly insured.³¹ Therefore, the introduction of green card resulted in the integration of poor citizens into the bottom end of the stratified health system in Turkey.

Lastly, research has indicated that the introduction of the green card scheme had not solved the problem of health system outsiders completely. The World Bank report on Turkey's health care system prior to the reform found that over one-third of citizens were not covered by any health insurance scheme, including the green card.³²

Inequalities originating from informal payments

Informal payments constituted another source of inequalities in access to health care services in the pre-reform health system of Turkey.³³ These

29 For an example, please see, Azer Kılıç et al., "Yeşil Kartın Vatandaşlık Rejimi," *Radikal* İki, November 10, 2008.

30 See, Adnan Kisa and Mustafa Z. Younis, "Financing Health Care For The Poor In Turkey: Is A Temporary Solution Becoming A Permanent Scheme?" *Public Health Reports* 121, no. 6 (2006): 764-768.

31 Sulku and Bernard, "Financial Burden," 12.

32 World Bank, *Turkey Joint Poverty Assessment Report Volume I* (Ankara: Human Development Sector Unit Europe and Central Asia Region and State Institute of Statistics of Turkey, 2005), vi.

33 See, Ata Soyer, *Bir Muhalefet Odağı Olarak Tabip Eylemleri, Bir Eylem Biçimi Olarak Beyaz Eylemler*

informal payments originated from the dual commitment of medical doctors to their private clinics and public hospitals and have been conceptualized in the literature as cases of “private finance-public supply” and “public finance-private supply,”³⁴ and these have been prevalent in other developing country contexts as well.³⁵

Two major causes could account for the existence of informal payments: the first was the privilege granted to medical doctors working in public hospitals to open and run private clinics without leaving their positions in public hospitals.³⁶ Given that the number of medical doctors in Turkey’s health system has generally been chronically low according to the population size, this privilege resulted in citizens using informal payments to get timely access to medical doctors. Secondly, citizens with high income were willing to distinguish themselves from lower-income citizens in order to bypass long queues and receive more attention from medical doctors.

Informal payments constituted a sizeable component of health care expenditures. In 2000, more than one-fourth of all health care expenditures were out-of-pocket.³⁷ Other research suggested that, also in 2000, 14 percent of the non-elderly population (younger than sixty-five) spent more than 20 percent of their family income on health care, while 19 percent spent more than 10 percent.³⁸ The greatest burden of informal payments was on the shoulders of the green card holders.³⁹ The prevalence of high levels of informal out-of-pocket expenditures in total health care expenditures implied the partial and informal commodification of health care services, especially for low-income groups, and the erosion of health care as a citizenship right.⁴⁰

(Istanbul: Sorun Yayınları, 2005); Fikret Adaman, “Study on the Social Protection Systems in Turkey,” in *Entry for the Report Study on the Social Protection Systems in the 13 Applicant Countries* (European Commission, 2003); Tolga Ersoy, *Türkiye Tıp Tarihi İçin Materyalist Notlar* (Istanbul: Sorun Yayınları, 1998).

34 Brian Salter, *The New Politics of Medicine* (Hampshire and New York: Palgrave Macmillan, 2004), 158.

35 World Health Organization, *Health Systems: Improving Performance*. In *The World Health Report* (Geneva: World Health Organization, 2000), xv.

36 Mehtap Tatar et al., “Informal Payments in the Health Sector: A Case Study from Turkey,” *Health Affairs* 26, no. 4 (2007): 1034.

37 The Ministry of Health of Turkey, 21.

38 Sulku and Bernard, “Financial Burden,” 10.

39 *Ibid.*, 11.

40 According to Bambra, three indicators can be used to assess the level of commodification of health care services: private health expenditures against total health expenditures, private hospital beds against total hospital beds, and the percentages of the population covered by public and private health insurance. Nevertheless, in health care systems within which informal payments play a significant role, these indicators might fail to reliably assess the level of commodification. The level of informal payments might be integrated to Bambra’s indicators as a fourth indicator in order to arrive at a better evaluation of the level of decommodification. For an as-is application of Bambra’s analysis

Nevertheless, it should also be noted that informality sometimes worked in the poor's favor. Before the launch of the HTP, scholars noted that outsiders could use informal strategies to get access to health care services. These strategies included, for instance, using an insured relative's social insurance number or green card to access outpatient services.⁴¹

To sum up, before the reforms, inequalities in access to health care services in Turkey mainly reflected the stratification of occupational status positions in the labor market; civil servants constituted the most advantaged group, while the unemployed, those out of the labor market and informal workers were highly disadvantaged. Despite the limited availability of informal strategies for the uninsured to get access to outpatient services, the existence of informal payments increased the financial burden upon those who were already in disadvantageous positions within this system and thus aggravated occupational status-based inequalities in access.

Health care reform in Turkey and its implications for access to health care

In the last two decades, most health care systems have been undergoing significant reform, and Turkey's health care system has not been exempt from this. After a series of failed attempts at reform throughout 1990s under consecutive unstable coalition governments, the AKP came to power as a single party government in 2002 and launched its HTP in 2003. The program paved the way for a series of reconfigurations in health care finance, health care provision and health care market regulation.

At the discursive level, providing easy and equal access to health care services lay at the center of the governments' appeal to the general public. The government legitimized the need for health care reform by criticizing the advantageous position of civil servants within the old system and claiming to address the grievances of green card users and the poor.

The HTP introduced two major changes: The first was the restructuring of health care provision, whereby the government transferred all public hospitals formerly owned by social security funds to the Ministry of Health (*Sağlık Bakanlığı*).⁴² These hospitals were then granted administrative and partial financial autonomy.⁴³ In the meantime, the

to the contemporary health system in Turkey, see, Agartan, "Marketization and Universalism."

41 Üstündağ and Yoltar, "Türkiye'de Sağlık Sisteminin Dönüşümü," 77-81.

42 See, *Bazı Kamu Kurum ve Kuruluşlarına Ait Sağlık Birimlerinin Sağlık Bakanlığına Devredilmesine Dair Kanun*, Law no. 5283, adopted on January 6, 2005.

43 See, *Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname*, Law no. KHK/663, adopted on November 2, 2011.

government provided incentives for the private sector to play a larger role in health care delivery and the Social Security Institution (*Sosyal Güvenlik Kurumu*, SGK) started to purchase services from the private sector hospitals.⁴⁴ As a result, the role of the private sector in health care delivery substantially increased and an internal market in health care provision was established. With the lifting of referral requirements, all those with public insurance—including green card holders—gained access to better quality public hospitals (i.e., the university hospitals). In addition, access to doctors in public hospitals has been facilitated due to the new requirement that such doctors work full-time hours in public institutions.⁴⁵ Lastly, the integration of private hospitals into the public health insurance scheme eased citizens' access to the majority of private hospitals, subject to an additional payment.⁴⁶

The second major change was the restructuring of health care finance. When compulsory General Health Insurance (*Genel Sağlık Sigortası*) was rolled out in 2008,⁴⁷ the three public health insurance schemes and the green card scheme were united. While this new financing model remained social insurance-based and maintained a residual tax-financed component for the very poor, it also introduced additional financing mechanisms: contributory payments for hospital visits and medication, additional payments for private hospital visits, and optional supplementary private health insurance.

These major changes in the provision and financing of health care services equalized the benefit packages for all those with public insurance as well as green card holders and eased access to health care services. This resulted in the effective abolition of occupational status-based inequalities among citizens in their access to health care services. As a result, research evidences that the gap between per capita health expenditures for different occupational status groups has been narrowing over time.⁴⁸

Research evidence reveals that the general public perceived the short-term impacts of the contemporary health reform as largely positive. In a nationwide survey in 2010, roughly 73 percent of interviewees expressed very high and high levels of satisfaction with health care services, while, before the reform in 2003, only approximately 40 percent of interview-

44 The share of both private sector investment in the health care sector and expenditures made for private hospitals from the SGK increased drastically during the reform. See Sönmez, *Paran Kadar Sağlık*, 60–71.

45 See, *Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun*, Law no. 5947, adopted on January 21, 2010.

46 Private hospitals that signed contracts with the SGK.

47 *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu*, Law no. 5510, adopted on June 16, 2006.

48 Teksöz, Kaya and Helvacioğlu, "Sağlık Reformunun Sonuçları," 4.

ees had expressed such satisfaction.⁴⁹ In a clear indication, the poor's relatively easier access to health care services than in the pre-reform period, the number of green card users increased from less than 7 million in early 2000s to almost 10 million in late 2000s.⁵⁰ Annual per capita hospital visits also increased from 1.88 in 2002 to 4.11 in 2010.⁵¹ Lastly, health care reform proved instrumental in securing public consent for the governing party in two consecutive general elections.⁵²

Despite high levels of satisfaction among the public and relatively easier access to health care services, it is hard to classify the overall impact of the reform on access as decommodifying or egalitarian. A recent study evidences that, after the reform, the share of out-of-pocket expenditures increased in total health expenditures, the number of households making zero out-of-pocket health expenditures decreased, and very poor households started to make more out-of-pocket payments for health care services.⁵³ While researchers interpret these results as a consequence of easing of access to health care services,⁵⁴ these results also suggest that the role of income levels in access to health care services has increased, and that income is becoming a new source of differentiation among citizens in the domain of health care.

This article identifies five dimensions of the current reform that demonstrate how it has introduced income level as a new source of inequality in access to health care services: 1) continuity in social insurance-based health care finance structure and the introduction of stringent income means testing; 2) the introduction of contributory payments for hospital visits in both public and private hospitals and medications; 3) the introduction of additional payments for private hospital visits; 4) the establishment of link between the quality of health care services and levels of contributory and additional payments, and; 5) the definition of a basic benefit package for public health insurance alongside the introduction of supplementary (private) health insurance. While the first dimension maintains inequalities inherited from the previous health care

49 Türkiye İstatistik Kurumu, *Yaşam Memnuniyeti Araştırması 2010* (Ankara: Türkiye İstatistik Kurumu, 2011), 29.

50 Sosyal Güvenlik Kurumu, *Primsiz Ödemeler Genel Müdürlüğü Eylül Ayı İstatistik Bülteni* (Ankara, 2010). In the early days of the reform, the government first simplified and accelerated the green card application procedure which greatly facilitated access to health care services for the poor. However, the government has recently introduced stringent means-testing procedures, as is discussed in the next section.

51 Sağlık Bakanlığı, *Sağlık İstatistikleri Yıllığı 2010* (Ankara: Sağlık Bakanlığı, 2011), 97.

52 Hüseyin Alkan, "AKP'nin Sağlık Kozu," *BBC Türkçe*, June 1, 2011.

53 Burçay Erus and Nazlı Aktakke, "Impact of Healthcare Reforms on out-of-Pocket Health Expenditures in Turkey for Public Insurees," *The European Journal of Health Economics* 13, no. 3: 338.

54 Ibid., 340.

system, the remaining four dimensions institutionalize income level as a new source of inequality in access to health care services:

Social insurance-based finance and means-testing

General Health Insurance, established by the reform as the new, single public health insurance, is a premium-based financing system. In this system, formally employed citizens are required to pay 5 percent of their monthly earnings, and employers 7.5 percent of their employees' monthly earnings, into the public health insurance fund. Citizens outside the formal labor market are obliged to pay 12 percent of their monthly income into the fund. Given that the reform dissociated health insurance funds from retirement funds, it opened up the possibility for citizens who are not formally employed to opt out of the public retirement system and contribute only to the public health insurance fund. According to the reform, contribution to the public health insurance fund is obligatory. In the previous financing model, the state's contribution to health care financing was limited to health care services for civil servants and green card holders. However, the reform obliges the state to contribute an amount equal to 25 percent of total premiums collected monthly to the public health insurance fund.

The reform equalized benefit packages for all those with public insurance, leading to the elimination of occupational status-based inequalities. However, the financing dimension of the reform still generates inequalities in access. One of the major problems of the former system was the failure of BAĞ-KUR to collect regular premiums, leading to the consequently indebted citizens being denied health care services. However, Turkey's post-reform health system also fails to address this problem, which continues to disadvantage people outside the labor force and the self-employed, including farmers.⁵⁵

Similar to the pre-reform health care financing system, the reform obliges the state to pay the premiums of those living under the green card income eligibility threshold. By preserving the income threshold at which citizens have to pay their own premiums,⁵⁶ and by continuing to

55 In 2009, more than half of the self-employed were indebted to the fund. See, Gülbiye Yenimahalleli Yaşar, "Review: 'Health transformation programme' in Turkey: an assessment," *International Journal of Health Planning and Management* 26, no. 3 (2011), 129.

56 For the period between June 1 and December 31, 2012, the following premium levels apply to the following ranges of monthly income per person in a family: 1) No premium to be paid by those living on less than one-third of the monthly minimum wage (₺313.50, or about €135); 2) A premium of ₺37.62 (about €16) for those living on between one-third and full monthly minimum wage (₺313.50-940.50, or about €135-405); 3) A premium of ₺112.86 (about €49) for those living on between minimum and twice monthly minimum wage (₺940.50-1,881, or about €405-810), and; 4) A premium of ₺225.72

oblige poor citizens to undergo stigmatizing means testing to gain access to health care services, the reform essentially left the inequalities in access to public health insurance untouched.

Changes in the means-testing procedures when applying for exemption from premiums indicate that income level has become a stronger determinant than before. While means-testing for green card applicants before the reform used applicants' employment status as its main criterion, the reform has introduced more stringent methods of income-based means testing. The new internet-based Social Assistance Information System (*Sosyal Yardım Bilgi Sistemi*, SOYBİS) enables state authorities to more closely monitor real and cash assets. The implementation of such stringent income means testing for premium exemption has already led to a significant decline in the coverage of this scheme.⁵⁷ For those left outside it, as the reform has also introduced stringent identity control mechanisms in public health facilities,⁵⁸ informal strategies to access health care services available before the reform (i.e., using an insured person's health insurance or green card) are also no longer available.

Therefore, the changes that the reform implemented in health care finance and their implications for citizens' access to health care services suggest that the reform did not, in fact, alter pre-reform occupational-based inequalities on the financing side. At the same time, the reform has made income the central element determining the eligibility of uninsured citizens to exemption from paying premiums to the fund.

Contributory payments

Another part of the reform that generates income-based inequalities in access is the introduction of contributory payments. As part of the reform, with the exception of primary health care services that remain free at the point of access, patients are obliged to pay contributory payments in order to access outpatient health care services and medication.⁵⁹ Contributory payments are flat rate payments, the amount of which varies according to the type of hospital to which a patient applies (either uni-

(about €97) for those living on over two monthly minimum wages (more than ₺1,881 or about €810).

57 By early 2012, SOYBİS had already enabled the cancellation of the green cards of 450 thousand individuals. See, "450 bin Yeşil Kart İptal," *Sabah*, January 14, 2012.

58 The SGK is planning to replace paper-based health certificates that have been used to identify the health insurance status of citizens with fingerprints in order to prevent ineligible outsiders using others' insurance. See, "Sağlıkta Parmak İzi Dönemi," *Milli Gazete*, December 9, 2005.

59 Patients are only exempt from paying contributions in cases of emergency, which is strictly defined as having an acute injury or illness that can cause the loss of life without immediate medical intervention and/or treatments including intensive care, ambulation care, cancer treatment, newborn services, organ, tissue and stem cell transplants, operations for congenital anomalies, dialysis, and cardiovascular operations.

versity or public) and is calculated on the basis of the number of visits and prescribed items.

The government claims that the introduction of contributory payments is a means of demand regulation to prevent unnecessary outpatient visits and excessive use of medication. However, regulating demand for health care services and medications through the introduction of a cash contribution does not affect all income groups on an equal footing. While the presence of contributory payments might not create a disincentive for middle- and high-income groups to make outpatient visits and use medications, it might substantially increase the financial burden of health care upon the poorer sectors of society and prevent them applying to health authorities, even in cases of urgent need.

One Turkish Medical Association (*Türk Tabipleri Birliği*, TTB) study clearly demonstrates that level of contributory payments has increased throughout the reform process.⁶⁰ The increase in the level of contributory payments led the total revenue collected from them to triple between 2009 and 2010.⁶¹ The level of contributory payments for outpatient visits and medications continues to increase.⁶² Such increases belie the government's declared objective of demand regulation and support the hypothesis that contributory payments are becoming a source of health care financing. Given that these increases have occurred at times of steady economic growth in Turkey, it could be argued that contributory payments have the potential to appear as a panacea for the financial burden of health care expenditures on the public budget during serious economic crises. Contributory payments are flat rate payments that are insensitive to patients' income levels. Thus any increase in their role in the financing of health care services implies a higher burden on low-income individuals and a deepening of income-based inequalities in access to health care services in Turkey.

Additional payments

The third dimension of the reform that generates and deepens income-

60 See table in Türk Tabipleri Birliği, "AKP Sağlık Politikası: Yalanlar ve Gerçekler," *Bağımsız İletişim Ağı* (BİANET), May 25, 2011.

61 "Tedavi Giderleri Arttı, İlaç Giderleri Sabit Kaldı," *Medimagazin*, March 28, 2011.

62 The rates of contributory payments at the time this article was drafted were as follows: ₺5 (about €2.15) for each outpatient visit to a public hospital; ₺12 (about €5.17) for each outpatient visit to a private hospital that offers services to the publicly insured; ₺3 (about €1.29) for each prescription, including up to three items of medication, and ₺1 (about €0.43) for each additional item. See, *Türkiye Cumhuriyeti Emekli Sandığı Kanunu ile Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun*, Law no. 6270, adopted on January 17, 2012; and SGK, *Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliğinde Değişiklik Yapılmasına Dair Tebliğ*, adopted on February 29, 2012.

based inequalities in access is the integration of private hospitals into public health insurance and the introduction of additional payments for private hospital visits. The reform split the purchaser and provider roles in Turkey's health system, and started to integrate private hospitals into the public health insurance scheme, granting insured citizens access to the majority of private hospitals in return for an additional payment.⁶³

This policy has created an income-based differentiation among citizens in terms of the hospitals they can get access to. Due to the inability of low-income citizens to make additional payments, they are expected to use public hospital services. On the contrary, middle- and high-income citizens prefer to apply for private hospital services and can afford the requisite additional payment. This trend opens the doors to middle- and high-income flight from public hospitals. This dimension of the reform thus paves the way to the segregation of hospitals for different income groups.

Linking levels of payments to quality of service

The fourth dimension of the current reform that aggravates access inequalities is the link it has established between the quality of health care services in hospitals and the level of contributory and additional payments. In this new configuration, levels of payments vary by the type of hospital (i.e., private or public university) and its placing on the quality categorization list prepared by the Ministry of Health.⁶⁴

In this model, the state subsidizes middle- and high-income citizens' access to private hospitals services. However, in 2010, the average cost of services by health care provider type was higher in private hospitals than in second-level public hospitals.⁶⁵ Thus the main implication of the state's subsidy of private hospital services is that the state spends more on health care services for middle and high-income citizens in comparison to low-income citizens.

The Social Security Institution (*Sosyal Güvenlik Kurumu*, SGK) announced a cap on the maximum amount of additional payment that a private hospital is allowed to charge. Private hospitals are allowed to make additional charges to patients below this cap and in line with the quality class they belong to. This cap has been steadily increasing since the launch of the program. Recently, the maximum amount of additional payments has become 90 percent of costs determined by the SGK for

63 Private hospitals that signed contracts with SGK.

64 The categorization on which this list is based is open to contestation: See, Ayşe Buğra and Volkan Yılmaz, "Sağlıkta Alınan Yol ve Ortaya Çıkan Tehlikeler," *Bağımsız İletişim Ağı* (BIANET), August 8, 2011.

65 Sosyal Güvenlik Kurumu, *Sağlık İstatistikleri* (Ankara: 2012).

private hospital services.⁶⁶ However, in practice, government attempts to regulate the level of contributory payments usually fails to prevent private hospitals (especially those located in metropolitan cities) charging patients over the permitted amounts of additional payments.

Therefore, the main negative implication of the link established between additional payments and service quality is its strengthening of the role of income as a means of differentiation and stratification of citizens' access to health care.

Basic benefit package and supplementary (private) health insurance

A last aspect of the reform that aggravates these income-based access inequalities is the definition of a basic benefit package for public health insurance and the consequent introduction of supplementary (private) health insurance.⁶⁷

With the aim of controlling future increases of health expenditures from the public budget, the reform strengthened the social insurance based financing model and introduced a basic benefit package for public health insurance. The SGK is now authorized to determine the types, amounts and durations of diagnostic services, medications and treatment services to be financed out of the public health insurance fund. The definition of this basic benefit package strengthens the influence of income level in access. For instance, exclusion of some medications from the basic benefit package requires citizens to make out of pocket payments to get access to these medications or purchase private health insurance.

The number of citizens purchasing standard private health insurance increased during the implementation of the reform.⁶⁸ As part of the reform, citizens are also able to voluntarily top up their public health insurance with supplementary health insurance. This is designed to provide financial protection from additional payments for health care services and medications provided by private hospitals offering services for the publicly insured. Expectations for this new market are high, and one of the leading firms offering supplementary private health insurance expects to reach 5 million consumers in five years' time.⁶⁹

66 "Özel Hastanede Farka Dikkat!" *Habertürk Ekonomi*, March 18, 2012.

67 See, Additional Article no. 58, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu*, Law no. 5510, adopted on June 16, 2006, and *Sosyal Güvenlik Kurumu, Tamamlayıcı ya da Destekleyici Sağlık Sigortası Uygulamaları Genelgesi*, no. 2012/25, issued on June 28, 2012.

68 While total number of citizens having entirely private health insurance was around 850,000 in 2004, this number had increased to roughly 2.3 million by October 2012. See, *Türkiye Sigorta Birliği, İstatistikler* (2012).

69 Mapfre Genel Sigorta, "Tamamlayıcı Sağlık Sigortası," accessed on January 20, 2013, <http://www.farkyoksigortasi.com>.

Thus, in addition to the partial commodification of services left out of the basic benefit package, the introduction of supplementary private health insurance also paves the way for the partial commodification of services defined as part of the basic benefit package. Such commodification strengthens stratification of access to services in the basic benefit package among the publicly insured as it offers middle- and high-income citizens the ability to differentiate the hospitals they use from low income citizens.

Concluding remarks

Prior to the reforms of 2002, the Bismarckian elements of Turkey's health care system generated occupational status based inequalities in access to health care services. The mismatch between social insurance-based financing and the structure of the labor market in Turkey further aggravated inequalities in access to health care. The system provided civil servants with the most advantageous position, while it excluded considerable numbers of the unemployed, informal workers and people outside the labor market. Even the introduction of the green card scheme to integrate the very poor failed to eliminate the problem. While the availability of informal strategies for uninsured people provided the excluded some limited access to health care services, the existence of informal payments in public hospitals exacerbated the financial burden on these citizens. Therefore, the primary origin of inequalities in access to health care services in Turkey's health care system before the reform were the inequalities among citizens' positions in the labor market which were reinforced by the occupational status positions codified in health insurance legislation.

The AKP's HTP promised to eliminate all the occupational status-based inequalities of the previous system (especially the privileged status of civil servants) and provide equal access to health care services for low-income citizens. Indeed, the reform initially had a clear egalitarian impact on access as it equalized benefit packages for all publicly insured citizens, eased access to health care services, and even decommmodified some treatments. However, the promise of equal access remains unfulfilled. Firstly, the reform fails to transcend the previous system's problems in health care finance because of the continuity in the social insurance-based health care finance structure and the introduction of stringent means testing for exemption from paying premiums. Secondly, the reform has led to the genesis of marked income-based inequalities in access to health care services. Such inequalities are effects of the introduction of contributory payments for medications and hospital visits in both public and private hospitals, the introduction of additional payments for private hospital visits, the establishment of link between the

quality of health care services and levels of contributory and additional payments, and the definition of basic benefit package for public health insurance alongside the introduction of supplementary private health insurance.

This article thus argues that the HTP has replaced occupational status as the primary origin of inequalities in access to health care with income. From an egalitarian perspective, occupational status based inequalities in access to health care services were just as unjustified as the new forms of income-based inequalities. Nevertheless, the political and economic implications of the shift to income-based inequalities will possibly overstep the bounds of a simple replacement of origins.

The direction of changes that the reform brought forward implies a shift in the general characteristics of Turkey's health care system. The new health care system in Turkey clearly relies upon a public-private partnership model in the provision of health care services, and the same trend is slowly becoming evident in the financing dimension. In this system, the state only guarantees free health care for very poor and citizens with life-threatening health conditions. Unlike the system before the reform, with its Bismarkian distribution of benefits among occupational status positions and informal access routes, Turkey's new health care system is operated on a modified market model that distributes benefits commensurate with people's market positions while providing guarantees for the most disadvantaged.

It should be noted that the income-based inequalities born after the reform pose a great threat to the realization of the social citizenship ideal. The reform process has created and strengthened its own political actors while leaving other actors less powerful. This is clear in the ever-increasing role of the private sector in health care finance and provision and the echo this creates in the power dynamics of the politics of health care. Private sector lobby organizations have gained political strength and are already a powerful pressure group pursuing a political agenda for further commodification of Turkey's health care services. The recent decision by the Council of Ministers (*Bakanlar Kurulu*) to increase the maximum rate of additional payments that private hospitals are allowed to charge patients from 70 percent to 90 percent of SGK price limits for services in private hospitals evidences this political tendency.⁷⁰

In contrast to the reform's favorable impact on the political power of the private sector in the politics of health care, the impact of the reform on trade unions and professional organizations has been overwhelming-

70 "Özel Hastanede Farka Dikkat!" *Habertürk Ekonomi*, March 18, 2012.

ly negative. The reform came into being as a result of a political process that excluded trade unions as well as professional organizations (especially the TTB), and the dynamics it creates clearly work against the establishment of a powerful opposition to the further commodification of health care. The recent law on trade unions effectively prevented trade unions adopting organizational structures able to pursue an effective political counter strategy against the emerging income-based inequalities in access to health care.⁷¹ The government also removed the founding principle of the TTB which authorized it to work for the efficient functioning of medical profession in line with the public good.⁷²

Despite the formal obstacles placed against the formation of a political movement to counter the commodification of health care services, it is encouraging that more than half of Turkish society still supports strong involvement of the state in health care.⁷³ If this support continues in the near future, it might constitute a societal base for a political force aiming at the reversal of dynamics of commodification and deepening income-based inequalities in access to health care services in Turkey.

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71 Despite trade union representatives' proposal to allow different forms of trade unions, including firm- and profession-based union as well as unions for the retired, the aged, the unemployed, the recent Law on Trade Unions and Collective Bargaining left the sector-based organization of trade unions intact. See, *Sendikalar ve Toplu İş Sözleşmesi Kanunu*, Law no: 6356, adopted on October 18, 2012.

72 Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname, No. KHK/663, adopted on November 2, 2011.

73 Ali Çarkoğlu and Ersin Kalaycıoğlu, *Türkiye'de Sağlık: Toplumbilimsel bir Değerlendirme* (İstanbul: Koç University and Sabancı University, 2012): 11.

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