Marketization and universalism: Crafting the right balance in the Turkish healthcare system

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Abstract
Turkey is undertaking comprehensive reforms in its healthcare sector which bring about a major transformation in the boundaries between the public and private sectors. As in many transition and late-developing countries reforms seek to universalize coverage, increase efficiency and improve quality of healthcare services. The Turkish case is interesting as it draws attention to the balance that is being struck between two major components of the reforms, namely marketization and universalism. Expansion of coverage and improvements in equity are taking place alongside state-induced market and managerial reforms. This article assesses the extent of marketization and argues that while market elements have been limited to the provision dimension, in the long run they may lead to some erosion in universalism. The Turkish case serves as an example of transformations in developing countries where market reforms have to be accompanied by a strong and active state for universalism to be achieved.

Keywords
Healthcare reform, marketization, new public management, transition and late-developing countries, Turkey, universalism

Introduction
Healthcare systems all around the world have witnessed waves of reforms since the early 1980s. A major theme in these reform initiatives has been the introduction or strengthening of market mechanisms as a response to the so-called ‘crisis’ which was defined, in
the comparative health policy literature, as the pressure to meet rising demand and growing costs in an environment of permanent fiscal crisis and global economic pressures (Defever, 1995; Gonzales-Block, 1997). In some advanced industrial countries, including among others the United Kingdom, New Zealand, Germany, Sweden and Spain, new public management (NPM) doctrines were based on a criticism of the inefficiencies of the public sector and have been viewed as the major driving force behind market-based reforms (Bergmark, 2008; Cabiedes and Guillen, 2001; Keaney, 2001; Pollock et al., 2004; Ranade, 1998). Claiming that public services can be improved by ‘more and better management’ (Clarke and Newman, 1997: 35), private sector theories and practices have been incorporated in various ways into healthcare systems. Examples of these include the use of contracts to regulate relationships among purchasers and providers, the establishment of autonomous public bodies to replace large government bureaucracies, the devolution of responsibilities and accountability to regional levels and setting clear standards of performance and quality.

The reform proposals announced by governments in late-developing countries, like Turkey and Mexico, or transition countries, like Macedonia, similarly combine these elements of marketization and NPM. Yet, in these countries, which have not created universal healthcare systems, governments are faced with different challenges. Many of these healthcare systems suffer from inadequate insurance coverage; lack of comprehensive benefits packages; barriers to access due to harsh geographical and weather conditions; massive migration to urban centres; significant problems in the distribution of healthcare resources, including facilities, equipment and personnel; prevalence of informal practices such as transfer of patients to private offices of physicians or informal payments to providers, which lead to major inequities (Datzo, 2006; Frenk, 1994; Islam and Tahir, 2002; Nordyke and Peabody, 2002; Saltman and Figueras, 1997). Thus, unlike their counterparts in advanced industrialized countries, while reforming their healthcare systems, policymakers in transition and late-developing countries had to come up with proposals to address these issues alongside market-based solutions.

Turkey is an interesting country to study the policy issues surrounding the marketization of healthcare services and managerial reforms in the context of development. Usually classified among the late-developing countries, Turkey began to move from a planned economy to a market economy in the early 1980s with policies of economic liberalization and stabilization that were introduced within the framework of a structural adjustment programme under the guidance of the International Monetary Fund and the World Bank. Yet, until recently, the extent of private markets in financing and providing health services has been minimal. The public sector dominated in the major functions of the healthcare system, similar to a command-and-control model of authority (Baldwin et al., 1998; Kutzin, 1995; Saltman and Von Otter, 1992). Since 2003, Turkey has undertaken the Health Transformation Programme (HTP), a comprehensive reform programme that introduced market incentives and mechanisms in the healthcare sector (MoH, 2003).

This article examines how the reform programme affects the particular ways in which boundaries among the public and private sectors are drawn and how roles and responsibilities are reallocated. Building on the literature on marketization and Bambra’s (2005) measures of decommodification, I assess the extent of marketization in the Turkish
context and identify the consequences of marketization in terms of (1) the role of the state and (2) access, equity and fragmentation in the healthcare system.

I argue that there are inherent contradictions among the HTP’s universalist aspirations and the market elements it has introduced. Universalism is generally defined as universalizing access and addressing social and regional inequalities. Given the persistent problems of access, especially in rural areas, and lack of health personnel and equipment in the underdeveloped regions of the country, full retreat of the state from service provision would exacerbate problems of accessing health services and lack of health personnel. Therefore, the HTP has not yet brought about the retreat of the state from direct service provision despite the Justice and Development Party (JDP) government’s commitment to the NPM paradigm. Unlike the advanced industrial countries with mature welfare states, late-developing countries like Turkey whose reform initiatives aim to achieve universalism alongside marketization, have to consider how market elements affect universal coverage and equity, and try to craft the right balance between universalism and marketization.

Research for this article draws on secondary sources such as official documents and statistical information from national and international databases (the Turkish Statistical Institute, the Ministry of Health, OECD and the World Bank); and additional searches of Turkish newspaper databases and web sources. Key policy documents such as the HTP summary report (MoH, 2003) and the subsequent progress reports issued by the Ministry of Health and the Ministry of Labour and Social Security, and World Bank reports (2003) and policy documents (2004, 2010) were reviewed as part of the research. The analysis builds on the comparative welfare state literature, and more particularly, on the growing literature on healthcare reforms in advanced industrial countries as well as in late-developing and transition countries.

The next section starts with a review of the concepts used in the comparative healthcare literature to analyse health reforms and their consequences. This is followed by a description of the Turkish healthcare system and an analysis of the reforms introduced within the framework of the HTP. Finally, I conclude by examining what these reforms mean in terms of the transformation of the state in the context of development. Ironically, market reforms in these healthcare systems have to be accompanied by a strong and active state for universalism to be achieved.

**Analysing marketization and universalism in the Turkish healthcare system**

Since the 1970s when the dominant role of the state in the healthcare sector was questioned in many countries, a number of concepts, such as marketization, privatization, managerialism and commodification, have been proposed in the broader social policy literature to describe the changing boundaries between the state and the market as well as the shifts in the balance of power among the public and private sectors.

*Marketization* can broadly be defined as the introduction or strengthening of market incentives and structures in the healthcare sector. This process may include diverse elements such as creating markets, encouraging competition among providers, giving greater choice and voice to patients, establishing financial incentives for efficient
resource utilization and higher quality of care and shifting decision-making and financial responsibility to service providers (Cribb, 2008; Nordyke and Peabody, 2002; Ranade, 1998). Marketization has also been linked to the rise of the NPM paradigm (Bergmark, 2008; Cribb, 2008; Keaney, 2001). Proponents of NPM advocate a fundamental shift in the role of the government from being the provider of public services to a regulator that ‘steers’ the ship, while the private sector along with the voluntary sector should do the ‘rowing’ via the direct provision of public services (Osborne and Gaebler, 1992). Furthermore, they propose incorporating market incentives and private sector practices into the management of public services as the best way to improve the efficiency of public institutions.

Marketization is closely related to another trend, namely commodification, which can be defined as the extent to which a country’s provision of healthcare services relies on the market and prices are determined by markets. The implications of marketization are clearly observed for the citizens whose access to these services becomes increasingly dependent on their market position. Consequently, the formally employed or wealthy citizens enjoy the highest quality services, whereas the informal sector workers and the poor have scant and irregular access, at best. According to Bambra (2005: 202), the following indicators may serve to assess the extent of commodification and decommodification: expenditure as a percentage of GDP as a measure of the extent of private financing; private hospital beds as a percentage of total bed stock to express the extent of private provision; and the percentage of the population covered by the healthcare system to understand the extent of general access provided by the public healthcare system.

Benefiting from these definitions and measures developed to analyse marketization and decommodification in healthcare systems, I focus on three indicators to assess the extent of marketization and describe the changes brought about by the HTP in provision and financing dimensions:

- Private health expenditure as a percentage of GDP;
- Private hospital beds as a percentage of total bed stock; and
- Number of private and public hospitals.

Private health expenditure as a percentage of GDP is used to measure the extent of private financing; share of out-of-pocket payments (OOP) is briefly discussed here to analyse the extent of financial protection provided by social insurance. In the Turkish case, out-of-pocket payments include fees for visits to public and private hospitals; additional fees for services provided in private health facilities; spending on diagnostic tests, pharmaceuticals and medical devices; informal payments to providers; and payments for private health insurance (MoH-PHD, 2006: 23). To express the changes in the extent of private provision, the number of private hospital beds as a percentage of total bed stock is examined alongside the number of private and public hospitals since 2002.

The second major dimension of the HTP, universalism, can be defined as ensuring equal access of the entire population to a uniform package of health-related services. One indicator of universalism is the general access provided by the public healthcare system measured by the percentage of the population covered by public health
insurance. The second major component of universalism is ‘equity’ among different categories of beneficiaries. I examine to what extent the HTP has addressed disparities among state employees, workers in formal employment, the self-employed and beneficiaries of means-tested programmes in terms of benefit packages, premiums and access to high quality services. On the basis of these indicators, the article aims to examine how the trade-off between universalism and marketization is experienced and practised so far.

Overview of the Turkish health system before the HTP

Turkey is categorized as an upper-middle-income country, but it ranks behind most middle-income and European Union accession countries in terms of population health status and in access to healthcare. Average life expectancy was 75.6 in 2007, slightly below the Organization of Economic Cooperation and Development (OECD) average (81.9), while the infant mortality rate is among the highest of middle-income countries, 22.6 per 1000 live births (OECD, 2010). Following the analysis of healthcare systems as suggested by Wendt et al. (2005), this section describes the Turkish healthcare system in terms of its three major functions, namely, financing, provision and regulation.

Financing and coverage

A dominant feature of the Turkish welfare regime is the role of social insurance, which provides healthcare and pension benefits for workers in formal employment. In the post-Second World War environment, which emphasized state-directed economic development, social security funds – the Social Insurance Organization (SSK) and the Retirement Fund (Emekli Sandığı) – were created top-down to provide some degree of protection to the privileged sections of the population, the industrial working class and retired state employees, respectively.

This social insurance system was highly fragmented, hierarchical and unequal, including significant differences among the social insurance funds in terms of benefit packages, premium rates, access to public and private facilities as well as the quality of services provided. Large segments of population were systematically excluded from the system: the rural populations who worked for themselves on their own land or as agricultural workers on other people’s land, and the urban poor who either worked in the informal sector or were out of work (Buğra and Keyder, 2006). In 1971, the establishment of the third insurance fund for the self-employed, the Social Insurance Organization for Craftsmen and Artisans and Other Self Employers (Bağ-Kur), expanded coverage of the social insurance system but did little to change the hierarchical structure.

At the top of the hierarchy were the active state employees and members of the Emekli Sandığı Fund, which was quite generous with the most extensive benefits package, good pensions and access to public, private and university hospitals. The Fund collected deductions from the salaries of state employees for pensions and healthcare services provided to retired state employees. Health expenses of active state employees, on the other hand, were paid by the institutions that employed them (through allocations from the government budget). Second in the hierarchy were the members of the SSK who had
privileged access to the hospitals owned and operated by the organization. This Fund was financed through the premiums paid by the members and their employers. Finally, only those members of the Bağ-Kur Fund who regularly paid health insurance premiums could benefit from public hospitals and private health facilities if the latter had contracts with the Fund. The premiums were set at 20% of the average income for active members and 10% of the pension for retired members, which constituted a major burden to these members. Low compliance in terms of paying the premiums for health insurance among the self-employed was a major barrier to access. As this summary of benefits indicates, the hierarchy among the funds was not based on the level of contributions but on closeness to the state and on employment status (Üstündağ and Yoltar, 2007).

The problem of limited coverage provided by public insurance was partially addressed in 1992 with the establishment of the Green Card Scheme (Yeşil Kart), which was a means-tested programme funded through the government budget. While expanding coverage to the poor, the scheme was quite limited in terms of benefits, covering only expenses for inpatient care provided by Ministry of Health hospitals and university hospitals upon referral. For their outpatient expenses, the Green Card beneficiaries could ask for reimbursements from the Social Solidarity Fund, which was financed through the government budget and administered by local committees. Yet, reimbursements depended on the availability of funds and hence were not guaranteed.

In 2002, 67.2% of the population was covered by the public system: the 2002–2003 National Household Health and Expenditure Survey estimated that 33.4% of the population was covered by the SSK, 5.1% by Emekli Sandığı and 11.7% by Bağ-Kur. The percentage of active state employees covered by their own institutions was 7.4%, while the Green Card Scheme covered 8.6% of the population (MoH-PHD, 2006). While 32.8% of the population had no insurance coverage, the percentage of the uninsured varied significantly among the regions of the country, with the highest percentage (45.7%) residing in East Anatolia and the lowest in Central Anatolia (26.8%) (MoH-PHD, 2006). Considering the financing of healthcare services, the data show that the extent of private financing was very limited. In 2002, Turkey spent 5.36% of its GDP on healthcare; the share of private and public expenditure on health was 1.57% and 3.79%, respectively (MoH, 2008: 115).

The public insurance system excluded those segments of the population who needed healthcare services the most, namely the poor and people living in less developed regions, since it did not reduce the burden of out-of-pocket payments. In 2002, Turkey’s out-of-pocket spending as a share of total healthcare expenditure was 19.8% and was much higher than in many OECD countries (MoH, 2008: 199). But more importantly, it varied with the type of insurance, lack of insurance, income levels and place of residence. The uninsured spent a higher percentage of family income on healthcare (MoH-PHD, 2006: 23), whereas those with lower incomes, those living in rural areas and in the Eastern Anatolian region and Green Card holders were at greater risk of high out-of-pocket burdens compared to the members of the insurance funds and those living in more developed regions (Sülkü and Bernard, 2008).

According to a recent study, in 2002, 25% of out-of-pocket payments were informal payments to providers, mostly for outpatient services (Tatar et al., 2007). As expected, formal insurance coverage did not protect patients against informal payments. First,
there was the widespread practice of doctors working in public facilities transferring their insured patients to their private offices. Second, mostly due to lack of resources in public hospitals, patients were asked to buy medications or other medical supplies like latex gloves, cotton pads or syringes. Some patients also reported under-the-counter payments to doctors, nurses and other healthcare personnel during inpatient stays in order to receive more attention and better services. These payments affected the poorer segments of the population and Green Card holders more than any other group (Tatar et al., 2007). Consequently, major inequities that existed between the rich and the poor as well as among the members of different social security funds were even reinforced.

Provision

Historically, the state has been the dominant actor in the provision of healthcare services in Turkey. Primary care was provided by health centres and posts owned by the state and staffed by doctors who were state employees. Provision of secondary and tertiary care was similarly the responsibility of the public sector, which consisted of the Ministry of Health (MoH) hospitals, the hospitals owned and operated by the Social Insurance Organization (SSK), university hospitals and a small number of hospitals operated by public institutions and municipalities. In 2002, there were 654 MoH hospitals, 120 SSK hospitals, 50 university hospitals and 20 hospitals owned by other public institutions. Taken together, public hospitals accounted for 90% of total hospital beds (TSI, 2010), while the share of the private sector in secondary care was overall low with 270 hospitals corresponding to 9% of hospital beds in 2002 (TSI, 2010).

Regulation

Prior to the HTP, the regulatory arrangements in the healthcare system can best be described as command-and-control, especially with respect to the providers. With its huge central and provincial bureaucracy, the state assumed responsibility in many areas, ranging from certification of the diplomas of newly graduated doctors and planning and regulating the employment conditions and remuneration system of physicians in the MoH hospitals and primary care centres to the monitoring of medical education. Furthermore, state agencies set general standards for insurance funds, such as the criteria for inclusion and the premium rates and co-payments. As a consequence, the role of the funds in regulating healthcare coverage and access was limited, and so were the benefits for citizens. As indicated earlier, there was no uniform benefit package; and access of patients to service providers varied depending upon the insurance fund to which they belonged. Moreover, in contrast to some other countries, such as the UK, the primary care system never functioned as a ‘gatekeeper’ in terms of controlling the access of patients to specialists (OECD/World Bank, 2008: 12).

In sum, until the announcement of the reform programme in 2003, marketization was fairly limited. The state was the dominant actor in all three dimensions of the healthcare system and was highly engaged in the regulation of the relationships between providers, financing agencies and patients. In contrast, non-governmental actors, like medical associations and trade unions, played a minor role, at best. Despite the minimal
role of markets in the healthcare system, commodification of healthcare was a growing challenge for the uninsured and the poor, who could not afford to pay formal and informal fees, and therefore could not access necessary services. Next to social inequalities, regional disparities also persisted; this was true for the distribution of resources and health personnel among the eastern and western parts of Turkey as well as among the urban and rural areas (MoH, 2003; World Bank, 2003). It was against this backdrop that the Health Transformation Programme was announced.

**Combining universalism with markets: The Health Transformation Programme**

True to promises made during the general elections in 2002, the Justice and Development Party (JDP) government announced its reform proposal, the ‘Health Transformation Programme’ (HTP) in December 2003. The HTP was drafted top-down by a reform team under the leadership of the Minister of Health without much participation of major stakeholders, like the unions or representatives of the medical association. Among the international policy actors, the World Bank emerged as an important participant in the healthcare reform debates. This dominant role was certainly a result of major funding (US$60.6 million) for the HTP (World Bank, 2004). The World Bank’s (2003) in-depth health sector study added further strength by serving as a strong analytical foundation for the reforms.

Enjoying the advantages of concentration of executive and legislative powers provided by the single-party majority government, the JDP began implementing the major components of the reform programme despite fierce protests from the unions and the Turkish Medical Association. Powerful laws came into force between 2004 and 2008 that aimed to reorganize the healthcare system and to dismantle the hierarchical insurance system. The following section examines the implementation of the HTP focusing on universalism, the adoption of market mechanisms and managerial reforms.

**Universalism**

The HTP emphasized universalism as one of its major priorities. Most of the documents where the JDP lays out its healthcare reform agenda refer to the problem of the ‘poor and uninsured’ segments of the population who had difficulty in accessing high quality services (JDP Party Programme, n.d.). The government proposed the establishment of a national health insurance scheme which would collect contributions on the basis of the ability to pay. Referring to the principle of solidarity and redistribution among the poor and rich, the sick and the healthy, the HTP was presented as a necessary step for the ‘social state’ to take (MoH, 2003).

Two pieces of legislation created a single-payer system by uniting all public funds under the Social Security Institution (SGK), namely the Administrative Unification of the Social Security System Act in 2006 (Act 5502) and the Social Security and Universal Health Insurance Act in 2008 (Act 5510). Participation in the national health system was obligatory; all citizens, except the Green Card beneficiaries, were asked to pay
contributions to the SGK. This single-payer system has undoubtedly enhanced equity by dismantling the hierarchy among the state employees, workers and the self-employed. As a result, a comprehensive benefits package was introduced where the insured have access to the same hospitals and enjoy the same benefits. In addition, the benefit package of the Green Card scheme was expanded to include outpatient services. A drug benefits programme was also created, and members were able to receive care from all public facilities and university hospitals. However, because it is based on the principle of social insurance, this system automatically excludes those citizens who work in the informal economy and those who are not poor enough to qualify for the Green Card programme.

Four policy initiatives were introduced in this context to improve access.

1. Children under the age of 18 are offered free care at any public facility regardless of the insurance status of their parents.
2. Primary care services are provided free of charge, although there have been some failed attempts recently to introduce co-payments. Even services provided at secondary and tertiary care level can be accessed, if the patient is able to convince the deputy chief doctor in charge of authorizing uncompensated care in the public hospitals.
3. Maternal services are covered until after the delivery (8 weeks for single pregnancies, 10 weeks for multiple pregnancies) under the public insurance and these services are offered free of charge to previously uninsured women.
4. Financial incentives have been introduced to encourage the participation in the insurance system of those previously insured citizens who cannot access healthcare services due to standing debts to the insurance funds. These citizens, mostly Bağ-Kur members, are allowed to pay their debts in instalments with lower interest rates.

Estimates of coverage rates for June 2010 suggest significant improvements towards universalism. Accordingly, 83% of the Turkish population were covered by national health insurance and an additional 13% were Green Card beneficiaries, expanding the coverage rate from 67.2% in 2002 to 96% in 2010 (SGK, 2010). According to a recent World Bank document the reforms have also expanded coverage among the poorest segments of the population, mostly due to the expansion in Green Card coverage; in 2003 only 24% of the poorest decile had health insurance, whereas by 2008, 82% of the poorest decile had coverage (SGK, 2010: 21).

All these changes represent significant steps towards the establishment of a universal healthcare system which ensures access free at the point of use and an effective cross-subsidy from the well and better-off to the ill and poor. The coverage rates are increasing, there are no exemptions for the wealthier groups, there is mandatory membership and efforts are underway to remove barriers to access. The HTP has also taken important steps towards achieving healthcare equity by introducing a single-payer system. Yet, the financing dimension, especially the scope of co-payments, should be examined more closely to assess the extent of universalism.
Marketization and managerial reforms

Major reforms in the Turkish social insurance system such as the unification of all insurance funds, adoption of a comprehensive benefits package and expansion of coverage to children under 18 slightly increased the share of total health spending of GDP from 5.6% in 2002 to 6.0% in 2007, but it did not lead to a significant shift in the pattern of financing healthcare. The public sector remained dominant with a share of 4.10%, though private financing also increased from 1.57% in 2002 to 1.9% in 2007 (TSI, 2010). Out-of-pocket spending as a share of total health expenditure was 21.8% in 2007, demonstrating a slight increase from 19.8% in 2002 (TSI, 2010).

The Social Security and Universal Health Insurance Act of 2008 (Act 5510) allowed for co-payments in the provision of outpatient services and sales of pharmaceuticals and other medical devices. Since 2008, the SGK set co-payment levels at 8 TL (Turkish lira) and 15 TL for outpatient services in public and private hospitals, respectively, while co-payments for pharmaceuticals and medical devices were kept at 20% for active workers and 10% for retirees. A co-payment of 2 TL was introduced for primary care services in September 2009 but this was cancelled after a decision by the Council of State – the highest court in Turkey. There were no exemptions for Green Card holders, though they could supposedly apply to local Solidarity Funds for reimbursements of these co-payments.

The Ministry of Health was also determined to limit informal payments and other unethical practices in the provision of care. Since the early days of the reforms, the Minister of Health himself has repeatedly pronounced informal payments as illegal and warned that doctors who accept these payments will be prosecuted. With increased cooperation of patients and strict enforcement some doctors were prosecuted, as news stories especially since 2009 demonstrate (CNNTurk, 2010; Hürriyet, 2010). In January 2010, despite protest from physicians’ associations, legislation was passed that ended the practice of public hospital doctors working part-time in their private offices after completing their work-hours in public facilities. This part-time work schedule has been blamed for increasing out-of-pocket payments as physicians transferred the patients they saw in public facilities to their private offices. Although this legislation was overturned by the Constitutional Court and its future is unclear, the Ministry of Health has demonstrated its determination to regulate healthcare provision more effectively.

The market direction of the HTP was perhaps most clear on the provision aspect. At the earlier stages of implementation, Prime Minister Erdoğan announced that free markets should be established in healthcare like in other sectors (Hürriyet, 2006). Reflecting the Party’s commitment to the entrenchment of the market economy, the JDP leaders publicly encouraged private investment in the hospital sector. These private hospitals were then allowed to sign contracts with insurance funds which made it possible for publicly insured patients to receive care in private facilities, though they were expected to pay the difference between what the insurance funds paid for and what the hospitals charged. As a result, the number of private hospitals increased to 365 in 2007 from 270 in 2002 (TSI, 2010) and the upward trend has continued. However, this increase was not reflected in the share of hospital beds, which was 9.7% in 2007 compared to 9.0% in 2002 (TSI, 2010). This was mainly because the
expansion of the private sector, in the earlier stages of the implementation of the HTP, was accompanied not by the privatization of public facilities but their consolidation under the roof of the Ministry of Health through the transfer of the SSK hospitals and other public hospitals. Hence balance between the public and private sectors has hardly changed. Yet, the expansion trend has to be a subject for further research, as data on outpatient care become available.

A major policy initiative to regulate and encourage provider competition, in accordance with principles of NPM, was the introduction of a strict separation of the insurance organizations from the providers, the so-called purchaser–provider split. The health facilities owned and operated by the SSK and municipalities were transferred to the Ministry of Health in 2005. After the establishment of the single payer (SGK) in 2006, competition was encouraged among public and private providers by assigning to the SGK the authority to selectively contract with the latter. MoH hospitals, on the other hand, were paid by bundled payments for inpatient and outpatient services and global budgets negotiated between the SGK and MoH. In this new healthcare market, in their new role as ‘consumers’, the publicly insured patients are given a free choice among the public and private hospitals, though they have to pay additional charges to the private providers according to the criteria determined by the MoH.

As seen in the experience of Spain, Italy and the UK, with NPM reforms, these initiatives to introduce market elements like competition, choice and financial incentives were accompanied by a neoconservative view of the state as an agency which should limit its role to regulating or ‘steering’ the private sector activity. In the early days of HTP reforms, the JDP leaders described the public health system as inefficient and prone to corruption, thus opening the way to a major restructuring of the public sector. One important component of this restructuring is the devolution of authority which, in the Turkish case, is mostly limited to transferring significant budgetary and managerial responsibility to public hospitals. Alongside new payment mechanisms like global budgets, performance-based payments or Diagnosis-Related-Groups (DRGs), budgetary and managerial autonomy – which will be granted with a draft Act yet to be passed at the time of writing this article in July 2011 – may herald a new era where public hospitals are managed just like private ones and become more market-oriented. They will have to compete with private providers, increase efficiency, find ways for quality improvement in service provision and emphasize cost-control.

In sum, in the aftermath of the HTP reforms, we are witnessing a significant transformation in the boundaries among state and market, public and private sectors in the healthcare system. While the public sector remains dominant in financing, the biggest transformation is taking place in the provision and regulation dimensions. Although the role of the private sector is growing slowly in service provision, the trend towards marketization is clear, with greater emphasis placed by the policy elite on the virtues of private provision and growing pressures on public hospitals to become more market-oriented.

At the same time, the Ministry of Health has been gradually withdrawing from the provision dimension through the purchaser–provider split and organization of public hospitals into autonomous units. It aims to focus on its recently recalibrated regulatory capacities like setting and monitoring quality standards at primary and secondary levels;
monitoring the prices of pharmaceuticals and medical devices; and experimenting with new payment mechanisms, in cooperation with the SGK, to control costs and increase efficiency in provision. Market mechanisms that were gradually introduced with the HTP are thus accompanied by the reassertion of the state’s regulatory power and maintaining a strong government commitment to healthcare financing. So, does this mean that the Turkish government got the health reform right?

**Conclusion**

Since 2003, within the framework drawn by the Health Transformation Programme, market elements, like competition and choice, have been introduced into the Turkish healthcare system. Within this context, patients have been assigned new responsibilities as shoppers in the marketplace who can ‘choose’ among public and private facilities. Competition was introduced with the purchaser–provider split, while the performance-based contracting and prospective payment methods introduced financial incentives. At the same time, the HTP refers to the principle of solidarity and redistribution. It has significantly improved access and equity through establishing a single-payer system. These developments raise questions about a contradiction in the Turkish reform programme.

The article has examined this contradiction and its implications in terms of the particular ways that boundaries between the public and private sectors are drawn. Undoubtedly, many advanced industrial countries with mature welfare states are faced with the challenge of ensuring social cohesion and social integration while introducing market elements aimed to increase efficiency and cut costs (Blomqvist, 2004; Cribb, 2008; Gerlinger, 2010). However, the Turkish case demonstrates that market reforms in late-developing countries create different challenges, like expanding coverage, improving access to healthcare services and fighting with informal practices and corruption. So, what do these reforms bring about in terms of the division of labour among the public and private sectors? What is expected of the state in the context of a late-developing country?

My research highlights that Turkey’s reform initiative, the HTP, leads to a major transformation in the role of the state. Similar to advanced industrial countries (Wendt et al., 2005), the state remains as the major actor in financing healthcare services; indeed, there is a trend towards strengthening state regulation of access to and provision of services. However, the JDP government in Turkey has faith in markets to deliver services more efficiently and has consistently encouraged private provision of healthcare services, although the experience with marketization is quite recent and the share of private provision is overall low in healthcare.

A universal health insurance system requires sufficient infrastructure and human resources to provide guaranteed services. In the case of Turkey, establishment of the single-payer system is not enough to guarantee universal access due to a number of problems, such as significant geographical barriers to accessing health facilities, inequalities in the distribution of health personnel and high quality facilities and informal payments that limit access to services. Expanding the share of private financing through co-payments or supplemental private insurance policies as well as withdrawal of the
state from service provision through establishing public hospitals as autonomous units and expanding the role of private providers, all would increase inequalities in access to healthcare. Despite their low share of hospital beds, the growing number of private providers has given rise to more socially stratified service consumption. The better-off patients, who can afford higher user fees, have a tendency to leave the public sector and prefer private providers. Therefore, full commitment to universal and equitable access calls for a strong state, including, among other things, the presence of high quality public hospitals with equal access to all citizens.

Turkish healthcare reform illustrates how particular dynamics of marketization in late-developing and transition countries may increase inequalities in accessing healthcare services. In these contexts, the state may not be able to retreat from service provision, and instead, has to strengthen its regulatory authority to steer the growing private sector. Expansion of private provision of services, in turn, calls for policies aimed at creating and enforcing effective regulatory mechanisms, as recent healthcare reform initiatives in Latin America, Central and Eastern Europe or Turkey demonstrate (Lakin, 2010; Nordyke and Peabody, 2002). In the healthcare system, market reforms have to be accompanied by a strong and active state for universalism to be achieved.

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References


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**Résumé**

La Turquie met en place des réformes globales de son système de santé qui transformeront radicalement les frontières entre secteur public et secteur privé. Comme dans de nombreuses transitions et des pays nouvellement développés, les réformes cherchent à rendre la couverture universelle, à accroître l’efficacité des services de santé et à en améliorer la qualité. Le cas turc est intéressant car il met l’accent sur l’équilibre entre deux éléments majeurs des réformes, à savoir la marchandisation et l’universalisme. L’expansion de la couverture et les réductions des inégalités sont mises en place parallèlement à un marché soutenu par l’état et des réformes managériales. Cet article évalue l’étendue de la marchandisation et soutient qu’alors que les éléments de marché ont été limités à la fourniture de services, sur le long terme ils pourraient conduire à une érosion de l’universalisme. Le cas turc est un exemple des mutations dans les pays en développement où les réformes du marché ont été accompagnées d’une volonté forte et dynamique de l’état en vue d’atteindre l’universalisme.

**Mots-clés**

Marchandisation, nouveau management public, réforme du système de santé, transition et pays nouvellement développés, Turquie, universalisme

**Resumen**

Turquía está emprendiendo reformas exhaustivas en su sector sanitario que darán lugar a una importante transformación de los límites entre los sectores público
y privado. Al igual que en otros países en transición o de desarrollo tardío, las reformas buscan la universalización de la cobertura, el aumento de la eficiencia y la mejora de la calidad de los servicios sanitarios. El caso turco es interesante puesto que dirige la atención hacia el equilibrio que se está tratando de encontrar entre dos de los principales componentes de las reformas, concretamente entre la mercantilización y el universalismo. La expansión de la cobertura y las mejoras de la equidad se están llevando a cabo junto al mercado inducido por el estado y las reformas en la gestión. Este artículo evalúa la extensión de la mercantilización y sostiene que mientras que los elementos del mercado han estado limitados a la dimensión de las provisiones, a largo plazo éstos pueden conducir a una erosión del universalismo. El caso turco sirve como ejemplo de las transformaciones que se producen en los países en desarrollo en los cuales las reformas del mercado han de ser acompañadas por un estado fuerte y activo para poder alcanzar el universalismo.

**Palabras clave**

Mercantilización, nueva gestión pública, países en transición y de desarrollo tardío, reforma del servicio de atención sanitaria, Turquía, universalismo