

THE POLITICAL ECONOMY OF MEDICAL TOURISM IN TURKEY

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THE POLITICAL ECONOMY OF MEDICAL TOURISM IN TURKEY

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"The Political Economy of Medical Tourism in Turkey" is a thesis prepared by Damla Fidan in partial fulfillment of the requirements for the Master of Arts Degree from the Atatürk Institute for Modern Turkish History at Boğaziçi University.

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Title: The Political Economy of Medical Tourism in Turkey

This thesis offers an explanation on the growth of medical tourism in Turkey. Along with the driving forces that created the ground upon which medical tourism industry could serve as an alternative, the thesis focuses on the role of the states in the creation and maintenance of the medical tourism market.

The emergence of medical tourism in Turkey has developed in parallel with cultural and economic globalization and transformation in healthcare systems. Economic and cultural globalization has enabled the ways in which movement of health personnel, international patients and medical devices have become easier. The transformation in healthcare systems has changed the scope of health as a welfare service. As First World countries strive to reduce their health budgets, medical tourism centers in developing countries constitute themselves as an alternative. Within this process, rather than retreating, the state has maintained its active role in regulating and monitoring of the markets. Alongside other actors such as private mechanisms and the NGOs, the state has become prominent in the growth of medical tourism in Turkey.

The Health Transformation Program, initiated in 2003, enabled the institutionalization of the industry. The governance and partial finance of medical tourism is carried out by government agencies whereas the provision of health services is mostly performed by private hospitals. Although it is viewed as a blessing to the economy, what kind of effects it has on the national health systems will emerge in the near future.

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Başlık: Türkiye'de Tıp Turizminin Ekonomi Politikası

Bu tez Türkiye'de tıp turizminin ortaya çıkışını incelemektedir. Tıp turizminin bir alternatif olarak ele alınmasına sebep olan faktörlerin yanı sıra tıp turizmi endüstrisinin oluşturulması ve sürdürülmesinde devletin rolünün ne olduğunu anlamayı amaçlamaktadır.

Türkiye'de tıp turizmi kültürel ve ekonomik küreselleşme ve sağlık sistemlerindeki dönüşüm ile paralel olarak gelişmiştir. Bu alanlardaki küreselleşme sağlık personelinin, uluslararası hastaların ve tıbbi cihazların dolaşımını kolaylaştırmıştır. Sağlık sistemlerindeki dönüşüm ise sağlık hizmetinin kapsamını değiştirmiştir. Gelişmiş ülkeler sağlığın bütçe üzerindeki payını azaltmaya çalışırken, gelişmekte olan ülkelerdeki tıp turizmi bir alternatif olarak belirlemiştir. Piyasadan çekilmek yerine, düzenleme ve denetleme mekanizmalarıyla devlet aktif olarak bu süreçte yer almaktadır. Özel sektör ve sivil toplum kuruluşlarıyla birlikte, devlet kurumları Türkiye'de tıp turizminin gelişmesinde önemli aktörler olarak öne çıkmaktadır.

Sektörün kurumsallaşması 2003'te başlatılan Sağlıkta Dönüşüm Programı ile mümkün olmuştur. Alanın yönetimi ve kısmi finansmanı devlet tarafından karşılanırken tıp turistlerine sağlık hizmeti sunumu çoğunlukla özel hastaneler tarafından gerçekleştirilmektedir. Tıp turizmi ekonomi için bir nimet olarak görülürken, yerel sağlık sistemleri üzerinde nasıl etkileri olduğu yakın gelecekte ortaya çıkacaktır.

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CHAPTER 1

INTRODUCTION

This thesis examines the dynamics that gave rise to the growth of medical tourism in Turkey. As medical tourism has emerged as an important industry in the last decade, it has come to constitute one of the main axes of health and trade policies. The issue came to the fore along with the Health Transformation Program in 2003. The institutional and financial base of medical tourism were partially established within the framework of these changes.

In parallel with the restructuring of the health system, the public-private relationship has received considerable attention with regard to privatization practices implemented by the state. Therefore, this thesis also seeks to address the expansion of medical tourism by analyzing the actors who have shaped the privatization and liberalization processes in the healthcare industry, including state institutions.

In this thesis, the medical tourism industry in Turkey is examined through two main lines of inquiry: The first one focuses on the development of the global medical tourism market, alongside driving forces such as economic and cultural globalization and the increasing acceptance of health as a commodity.

The second line of the inquiry lies upon the role of states in the growth of the industry. As medical tourism is led by the private sector, private forces dominate the provision of health services. However, states play crucial roles in terms of regulating and monitoring the markets.

The medical tourism industry in Turkey is given particular emphasis as to the current size of the industry along with the role of the state institutions in the domains of governance, finance and provision of medical tourism activities. In addition, Health

Transformation Program is addressed in detail in order to comprehend how recent systemic changes have served the growth of the industry.

Medical tourism can be defined as “the organized travel outside one’s natural healthcare jurisdiction for the enhancement or restoration of the individual’s health through medical intervention.”¹ Even though there is a tendency to identify medical tourism with the utilization of complex medical procedures, some scholars opt to develop a more inclusive yet minimalistic outlook in understanding the recent changes in health travel. For example, Bookman and Bookman assume an underdeveloped definition, classifying medical tourism activities as travel for the purpose of improving one’s health condition.²

There exist different approaches in defining medical tourism and no unified characterization could be put forward by medical tourism scholars. Concepts such as health tourism and healthcare tourism³ are also in use, albeit depicting different aspects of travel for health purposes. However, it is crucially important to define the unit of analysis prior to the research as data on figures vary according to the definition. In this thesis, medical tourism is addressed as a subset of health tourism.

Health tourism, which has been substantial for decades, could be identified as a wider concept that is comprised of any travel out of one’s own health jurisdiction, for the maintenance, enhancement or restoration of the individual’s well-being in mind

¹ Percivil Carrera, John Bridges, “Globalization and Healthcare: Understanding Health and Medical Tourism” *Expert Review of Pharmacoeconomics and Outcomes Research* 6, no. 4 (August 2006): 447.

² Milica Zarkovic Bookman, Karla Bookman, *Medical Tourism in Developing Countries* (Palgrave MacMillan: New York, 2007): 1.

³ Jonathan Goodrich, Grace Goodrich, “Health Care Tourism- An Exploratory Study” *Tourism Management* 8, no. 3 (September 1987): 218.

and body.⁴ However, medical tourism is constricted to more complex treatments that require medical intervention. It varies from cosmetic procedures to cardiovascular operations.

Medical tourism is a longstanding phenomenon which was brought onto the public agenda with the liberalization of health services and the shifts in the understanding of welfare provision. The restructuring of the world economy to accommodate the demands of the markets created a space for the free movement of goods, services, and people. The expansion of the medical tourism industry was made possible by the opening up of national markets to foreign capital.

On the other hand, perceiving health as a commodity eased the way in which medical tourism could present itself as an alternative to slow or insufficient functioning national health systems in some developed countries. Instead of waiting for long periods of time for certain medical procedures, patients can opt to travel overseas by paying out of pocket. In addition, diffusion in information technologies, fewer restrictions on movement, and low cost air travel have made traveling abroad for medical care more feasible.⁵

The flow of medical tourism historically was from lower to higher income countries, which had better medical facilities and highly trained and qualified professionals. However, this tendency is now reversing as lower income countries attract foreign patients by applying Western standards in medical services.

The “reverse” global flow has been regarded as the main element of medical

⁴ Percivil Carrera, John Bridges, “Globalization and Healthcare: Understanding Health and Medical Tourism” *Expert Review of Pharmacoeconomics and Outcomes Research* 6, no. 4 (2006): 447.

⁵ The HWN Team, 11 May 2009, *Medical Tourism and Global Healthcare - Where Are You Going?* <http://healthworldnet.com/articles/heads-or-tails/medical-tourism-and-global-healthcare-where-are-you-going.html> [19 May 2015].

tourism as there is an increasing number of international patients opting to travel to developing countries for cheaper and qualified medical services. Among the top medical tourism destinations in 2012 were seven countries from the developing world.⁶ As seen in the table, most of the countries that record high numbers of medical tourist are from the developing world which signifies the reverse aspect of international medical mobility.

Table 1. Top Medical Tourism Destinations, 2012

Country	No. of tourists	Niche market
Thailand	1.2 million	Sex-change operations and cosmetic surgery
Mexico	1 million	Dental work and weight loss
United States	800,000	Cardiac
Singapore	610,000	Cancer treatment and organ transplant
India	400,000	Fertility, cardiac, orthopedic and oncology
Brazil	180,000	Cosmetic surgery
Turkey	110,000	Cardiac, orthopedic, eye treatment
Taiwan	90,000	Full facelift

Source: DTLL Global Life Sciences Industry Group Analysis of Patients Beyond Borders Data, 2012

It is not clear when and how the recent version of medical tourism has revived. It has been asserted that the Asian financial crisis in 1997 caused many Southeast Asian nations to search for alternative strategies to cope with their declining financial figures by attracting foreign patients.⁷ Although the emergence of medical tourism may correspond to different time frames in different countries, the drivers behind the

⁷ Leigh Turner, "First World Health Care at Third World Prices: Globalization, Bioethics and Medical Tourism" *BioSocieties* 2, no. 3 (2007): 312.

efforts to stimulate the industry resemble each other.

Medical tourism has been regarded as a major source of foreign exchange, a tool for increasing economic growth in the spheres of tourism, transportation, hotels, pharmaceuticals, and providing employment for young populations. It also has the potential to raise gross domestic product and create a favorable balance of trade by lowering the fiscal deficit of the national economy.⁸

In terms of generating foreign exchange, medical tourism has proved itself to be a good source. It is estimated that the market size is US\$38.5-55 billion, based on approximately eleven million cross border patients spending an average of US\$3.500-5.000 per visit, including all medically-related costs, cross border and local transportation, inpatient stay and accommodations.⁹ Ultimately, medical tourism improves the image of the country by acting as a reliable and efficient health care provider.

The main exporting countries of medical tourism (those who provide medical service to foreign patients) are situated in all parts of the world, including Latin America, Eastern Europe and Asia. The importing countries, on the other hand, are mainly in Europe and North America. Long waiting lists and high costs are among the basic reasons that incline patients to international medical mobility.

The cost of treatments in some medical tourism destinations are often a quarter to one-tenth of the price of those in developed nations.¹⁰ Another important reason for

⁸ Annette Ramirez de Arellano, "Patients without Borders: Emergence of Medical Tourism" *International Journal of Health Services* 37, no. 1 (2007): 195.

⁹ 6 July 2014, *Medical Tourism Statistics and Facts*, <http://www.patientsbeyondborders.com/medical-tourism-statistics-facts> [18 May 2015].

¹⁰ Mike Adams, 21 April 2015, *Rising Popularity of Medical Tourism Reveals Deterioration of U.S. Healthcare System*, http://www.naturalnews.com/007097_Medical_tourism_healthcare.html [19 May 2015].

opting for medical tourism is the provision of services that are illegal in many developed countries (such as facelifts, hair transplants, dental treatment, and liposuction) or which take long legal procedures to obtain (such as surrogacy and organ transplant).¹¹

In addition to the reverse flow of foreign patients from developed nations to the developing world, there are also people from underdeveloped countries who travel to other countries for better treatment facilities. Patients from countries such as Libya and Iraq who travel to Turkey fall into this group as they do not reflect the “reverse” aspect of medical tourism.

One significant characteristic of medical tourism, in addition to its 'reverse' character, is that it is positioned on health and trade axis, with particular emphasis on tourism. Gibson writes that it could be regarded as “a hybrid economic formation blending different industries, the state, nature, the informal sector, the capitalist and non-capitalist economies, and all manner of technologies, commodities and infrastructure.”¹²

Defining medical tourism only within the framework of health and travel would be misleading since commercialization is at the heart of the growth in medical tourism.¹³ It is a global industry with a range of stakeholders with commercial interests, including brokers, healthcare providers, insurance provision, website

¹¹ Leigh Turner, “Medical Tourism, Family Medicine and International Health-Related Travel” *Canadian Family Physician* 53, no. 10 (October 2007): 1640.

¹² Chris Gibson, "Geographies of Tourism: (Un)ethical Encounters" *Progress in Human Geography* 34, no. 4 (August 2010): 529.

¹³ Neil Lunt, Marianne Hardey, Russell Manion, “Nip, Tuck and Click: Medical Tourism and the Emergence of Web-based health information” *The Open Medical Informatics Journal* 4 (2010): 2.

providers and conference and media services.¹⁴ All these components of the industry have varying interests in the expansion of the industry, and this is partly due to the provision of services primarily by the private sector.

Multinational and business enterprises strive to develop marketing strategies, pricing, branding, management and maintaining the quality of services. The availability of web-based resources and extensive usage of technological devices have partly eased the increase in the commercial interests of the stakeholders.

Although medical tourism has significantly expanded in the recent past, the lack of reliable and comparative data continues to obstruct rational analysis. Not only comparable information on the number of travelers or the amount of money they spent on travel is available, but the concepts and definitions of medical tourism are not standardized.¹⁵

Also, deficiency in information about how patients access, choose and process medical information given by the agencies or web-sites constitutes one of the impediments to a well-developed analysis. Lack of data is not limited to patients' choices, but is also apparent in market figures. Different estimations are put forward by international companies in accordance with how they define medical tourism activities, and their results vary accordingly.

The liberalization of economies and acceptance of health services as a commodity have expanded the scope of medical tourism industry with the help of new information technologies. The growth of medical tourism in Turkey has experienced a similar pattern as its developing counterparts. One important feature of medical

¹⁴ "Medical Tourism: Treatments, Markets and Health Sytem Implications: A Scoping Review" (OECD: Directorate for Employment, Labour and Social Affairs, 2011): 18.

¹⁵ Nathan Cortez, "Patients without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care" *Indiana Law Journal* 83 (2008): 73.

tourism in Turkey is that it has been enabled by the systemic changes brought about by the Health Transformation Program in 2003 by the Justice and Development Party (*Adalet ve Kalkınma Partisi*).

In this respect, it is crucial to underline that the state has been a leading actor in regulating, monitoring and financing of the medical tourism industry. Although health services are mainly delivered by private hospitals, state institutions remain influential on the creation and functioning of the market. In addition, health NGOs, such as the Association for Accredited Hospitals (*Akredite Hastaneler Derneği*) and Association for Private Hospitals and Health Institutions (*Özel Hastaneler ve Sağlık Kuruluşları Derneği*) have taken active part in regulation processes.

The Ministry of Health, the Ministry of Economy, and the Ministry of Culture and Tourism are the key state institutions that have assumed responsibility over the promotion and regulation of the industry. This is partly due to the understanding of medical tourism as an export item which is highlighted with cultural assets.

The Ministry of Health categorizes medical tourism as a subset of health tourism which also includes elderly/disabled tourism and wellness/spa tourism. Hence, medical tourism is addressed within the larger framework of health tourism in policy reports. Health tourism, on the other hand, is identified as travelling to a different location for enhancing health conditions.¹⁶ Stay time should last more than 24 hours to consider someone as a health tourist. These patients are made certain flight discounts if they make arrangements for a period longer than 24 hours.

As mentioned at the beginning of the chapter, this thesis basically seeks to understand the development of medical tourism in Turkey. In this regard, government

¹⁶ "Türkiye Medikal Turizm Değerlendirme Raporu 2013" (Ankara: T.C. Sağlık Bakanlığı, 2013): 18.

reports, national development plans, civil society publications (those who work for the promotion of medical tourism), international consulting firms' reports, news and previous academic literature have been analyzed.

The medical tourism literature in developing countries mainly focuses on development debates as to whether medical tourism could promote improvement in health systems for local patients. Although development issues such as brain drain (returning of doctors from developed countries to work at private hospitals in their home countries) have been adequately analyzed in other countries such as Singapore and Malaysia, the Turkish case remains scanty in terms of quantitative and qualitative studies. Researches that address issues such as brain drain and recovery for local patients will significantly contribute to the medical tourism literature in Turkey.

This chapter aims to provide a general outlook on basic statistical and conceptual aspects of the global medical tourism market. The expansion of the industry has been enabled in consequence of structural economic changes. The liberalization of healthcare services in accordance with the global reach of market relations propelled the establishment and growth of the medical tourism industry. Familiarity with distant cultures via technological devices and the accessibility of information through web-based resources represented medical tourism as an alternative to long waiting lists and high treatment costs at home.

In Chapter Two, global dynamics that brought out the development of medical tourism are analyzed. Globalization and transformation in healthcare systems could be regarded as two major impetuses behind the growth. In this regard, economic globalization enables the ways in which capital, services and labor can mobilize without restrictions.

In line with these, the General Agreement on Trade in Services (GATS),

which came into force in 1995, is addressed to provide an in-depth understanding of how health care services came to be called as “consumption abroad”. Cultural globalization will also be examined to comprehend the factors that eased cross -border patient mobility.

Healthcare systems, on the other hand, have been affected in a context where governments are entrapped by the neoliberal expansion. Structural changes in the world economy influence the ways in which states provide health services to their citizens. Rising costs and demands for services encouraged governments and private sector to shift responsibility for one’s health to the individual. In addition, the outsourcing of healthcare services has become an important tool in decreasing costs.

In Chapter Three, the transformation of the Turkish healthcare system is discussed in its relation to the expansion of medical tourism industry. In order to reclaim a better understanding of the recent changes, welfare character of the state and basic developments in the health system will be discussed in the first place.

The Turkish welfare system designated an inegalitarian-corporatist model which reflects an employment-status based social security system. Accordingly, there existed a hierarchical structure which divided citizens along occupational lines. Along with the Health Transformation Program, different social security schemes were united under one institution, abolishing the occupational hierarchy in health care provision. However, high rates of informal activity continue to be a major problem since the new health system is constructed upon a premium-based model.

Other objectives of the Program could be listed as; the restructuring of the Ministry of Health, family medicine, strong referral chain, and autonomous healthcare enterprises. Such changes partially enabled the ways in which medical tourism could be institutionalized and could develop as an export item that attracted attention from

government agencies.

Considering the fact that medical tourism is driven by the for-profit private sector in health systems, the increasing involvement of private mechanisms contribute to the development of the industry. Foreign direct investment, which is the primary driver behind the efforts to expand the sector, in the health sector is thus expected to rise with some wide scale health projects such as free health zones which aim to bring all kinds of health centers in one area (i.e., spa centers, research and development centers, hospitals).

Chapter Four focuses on the role of states in the medical tourism market. Along with the financial and promotional assistance provided by the state institutions, creation and regulation of the market are also performed by the state. In this respect, the degree to which the medical tourism market is controlled by the state will be discussed.

Chapter Five scrutinizes medical tourism in Turkey. The current size of the industry will be given with further information about the international patients coming to Turkey each year. Along with a general overview, regulation, finance and provision aspects of medical tourism will be elaborated in a detailed perspective.

In Turkey, the regulation and monitoring of medical tourism market are performed by the Ministry of Health. Moreover, the Ministry of Culture and Tourism and the Ministry of Economy are influential in policy-making processes. The finance of the industry, which is addressed with a dual approach in this thesis, has been substantially supported by state institutions. The first part assesses the financing of medical tourists. In this respect, international patients are categorized within four major groups under the Ministry of Health reports, basically in regard to their financing.

The second part elaborates the finance of investments in medical tourism. It is possible to argue that there is a strong support from government bodies in the form of various financial incentives. Lastly, the provision of health care services within the framework of medical tourism is mostly carried out by the private sector. Public hospitals strive to serve regular tourists who need emergency services and patients of bilateral health agreements.

Within the context of policy-making, the industry has received considerable emphasis in recent years. According to the 10th Development Plan, health tourism is cited an area which can create employment because of its labor intensive structure.¹⁷ In the health tourism report of the Ministry of Health, health tourism is described as an export item which has strategic importance. Financial support of US\$ 300 000 is given every year to those who invest in the medical tourism sector. Turkish Airlines offers certain discounts to patients who travel to Turkey as medical tourists. Government agencies organize medical tourism conferences and trade fairs to attract foreign entrepreneurs.

Given all of these efforts, it is possible to argue that medical tourism constitutes one of the basic axis of trade and tourism policies of the government. In parallel with these attempts, laws that ease the entrance of foreign direct investment in the country will be addressed.

¹⁷ "Onuncu Kalkınma Planı (2014-2018)" (Ankara: T.C. Kalkınma Bakanlığı, 2013): 11.

CHAPTER 2

DEVELOPMENT OF GLOBAL MEDICAL TOURISM INDUSTRY

This chapter provides an overview of the medical tourism industry, and explores the factors that have triggered its emergence and development. On the grounds that medical tourism has come to constitute one of the basic components of trade and health policies in the last decade and generates about US \$55 billion annually, the factors that stimulated its growth have gained importance. In this regard, conceptual approaches to international medical activities will first be analyzed to better situate medical tourism debates in the literature. Then, globalization and change in coverage of healthcare services will be discussed as the main drivers behind the expansion of the industry.

A General Overview on Medical Tourism Literature

Medical tourism denotes traveling across international borders to receive some form of medical treatment. Carrera and Bridges define medical tourism as “organized travel outside one’s natural health care jurisdiction for the enhancement or restoration of the individual’s health through medical intervention.”¹⁸ It includes medical procedures such as cosmetic surgery, dentistry, cardiac surgery, orthopedic surgery, bariatric surgery, fertility/reproductive system operations, organ, cell and tissue transplantation, eye surgery, diagnostic and health check-ups. Although there appears to be a lack of consensus regarding the definition of international medical care, some

¹⁸ Carrera and Bridges, 447.

characteristics appear to be common in describing such activities: medical intervention (mostly involving technological procedures), organized and international travel.

A wide range of nomenclature has been introduced to describe the international movement of patients for treatment purposes. Although scholars point out similar characteristics that encompass medical tourism, they opt to designate different terms. International medical travel, medical refugees, medical outsourcing and bio-tech pilgrims have all been put forward for naming the movements of international patients. It is crucial to note that the term “medical tourism” has been widely accepted in the literature to indicate international travels for health purposes.

Medical tourism, in general, is identified as a subset of patient mobility.¹⁹ It is distinguished from health tourism in so far as the differences regarding the types of intervention and settings. In medical tourism, bio-medicine is essential as compared to alternative medicine approaches in health tourism. In addition, hospitals and clinics are considered as settings of medical tourism activities whereas non-medical facilities constitute the main components of where health tourism takes place. In this regard, medical tourism could be best separated from health tourism by virtue of its necessity of involving medical technology of the operative kind for surgical procedures.

Health tourism, in general, is defined as “the organized travel outside one’s local environment for the maintenance, enhancement or restoration of an individual’s well-being in mind and body.”²⁰ Health tourism contains a full range of activities that are carried out for the purpose of enhancing the individual’s mind and body, including wellness/spa and thermal therapies and surgical operations. In this respect, as

¹⁹ Neil Lunt, Percivil Carrera, "Medical Tourism: Assessing the Evidence on Treatment Abroad" *Maturitas* 66, no. 1 (May 2010): 28.

²⁰ Carrera and Bridges, 447.

presumed in this thesis, medical tourism is regarded as a subgroup of health tourism.

On the other hand, there exist criticisms concerning the use of the term medical tourism. These criticisms originate from the utilization of the term “tourism” in defining medical activities. Rejections are shaped around the connotations of lightness and relaxation that the word “tourism” represents.

Glinos et al. argue that “medical tourism” is an industry-driven term that presents leisurely traveling and does not capture the seriousness of most patient mobility.²¹ In the same line of arguments, Kangas points out to the sufferings of patients that the term “medical tourism” falls short of representing.²² “Medical tourism” is considered as a misnomer, carrying connotations of pleasure that disregards the seriousness of the travel.²³ The usage of the term “tourism” has been marginalized by such authors who insist that medical tourism underestimates the sufferings of patients and mostly represent leisure. Moreover, the denotation of medical tourism as a market activity was kept scholars from using the term. However, considering the tourism aspect of marketing strategies fostered by the promotion agencies (both public and private), the term “medical tourism” fully implies the basis upon which the industry has grown.

“Medical tourism” indicates the involvement of technology-intensive medical procedures as well as referral to market related forces. As it is situated within the debates of changing health care services and liberalized global economic system, the

²¹ Irene Glinos, Rita Baeten, Matthias Helble, Hans Maarse, "A Typology of Cross-Border Patient Mobility" *Health Place* 16, no. 6 (2010): 1146.

²² Beth Kangas, "Traveling for Medical Care in a Global World," *Medical Anthropology* 29, no. 4 (October 2010): 350.

²³ Andrea Whittaker, "Pleasure and Pain: Medical Travel in Asia," *Global Public Health* 3, no. 3 (2008): 280.

term fits well in the domains of health and trade policies. The tourism aspect of the industry, in this sense, refers to the market driven character of medical activities rather than its leisurely facet. Hence, in this thesis, the utilization of the term “medical tourism” is chosen for two reasons: it conveys the technology-intensive component of medical treatment to international patients as well as its relation to market dynamics; and the promotion strategies of the industry by national governments are established upon this term. Although policy makers opt for other categorizations, such as “international patients” and “health tourists”, their reference to medical tourism more or less corresponds to the definition given above.

Health-related travels historically have been substantial since Ancient times. The first known medical tourists were ancient pilgrims who traveled to Epidauria at the Saronic Gulf from all over the Mediterranean.²⁴ In more recent times, the rich and aristocrats traveled abroad to spa towns and sanitariums for mineral baths and mild climates to improve their health.²⁵

During the twentieth century, wealthy people from less developed countries traveled to the developed world to receive better medical facilities from qualified health professionals. Recent travels for health-related purposes signify a reverse flow from developed countries to the developing world. This shift constitutes one of the core aspects of medical tourism. Reverse flow of patients from developed countries mostly to the developing nations originates from long waiting lists or high cost medical treatments at home. On the contrary, exporting countries (those who offer

²⁴ Abdullahel Hadi, "Globalization, Medical Tourism and Health Equity" (paper, Symposium on Implications of Medical Tourism for Canadian Health and Health Policy, Ottawa, November 13, 2009): 3.

²⁵ Harriet Hudson Gray and Susan Cartier Poland, "Medical Tourism: Crossing Borders to Access Health Care" *Kennedy Institute of Ethics Journal* 18, no. 2 (2008): 195.

services) promise high-standard medical treatments from qualified health personnel in short wait times.

The emergence of such a sector in developing countries was enabled by the liberalization of healthcare services and the change in the understanding of health as commodity. These underlying factors could be regarded as outcomes of broader processes such as globalization and health care transformation projects. Moreover, the inclusion of third parties (alongside with service provider and beneficiary) such as travel agencies, brokerage companies, and website providers are significant elements in defining medical tourism.

Low cost airlines, technological advancements, cultural familiarity have all contributed to the emergence of medical tourism sector as a new form of international medical mobility which is different from earlier forms of health-related travels.

The importing countries of medical tourism are mostly developed nations such as the United States, Britain, Australia, the Middle East and Japan.²⁶ Although Thailand, Singapore, Turkey, Malaysia, India, Panama, Costa Rica and the UAE (particularly Dubai) appear as the most popular exporting countries, the industry has witnessed rapid growth in other parts of the world. While there is general agreement that the industry has expanded within the last decade and it promises further expansion in the future, there remains disagreement as to the current size of the industry.²⁷ The disaccord on the size of the industry arises from different definitions of medical tourism. Estimates mostly rely upon the consultancy reports and lie somewhere between 30 and 50 million medical tourists traveling for treatment each year. US

²⁶ Hadi, 3.

²⁷ "Medical Tourism: Treatments, Markets and Health Sytem Implications: A Scoping Review" (OECD: Directorate for Employment, Labour and Social Affairs, 2011): 13.

tourists are thought to constitute roughly 10 percent of global medical mobility.²⁸ The industry, on the other hand, is considered to have risen to \$100 billion in 2012, based on a McKinsey and Company report.²⁹

The implications of medical tourism on exporting countries are discussed within development debates. It is much elaborated in the literature as to whether medical tourism could promote development in developing countries.

Medical tourism has been both regarded as a blessing to the economy and as a threat to the national health systems.³⁰ Issues such as brain drain (from public hospitals to private hospitals), recovery for local patients and financial deprivation of medical professionals who are delivering world class health services at Third World prices attract significant attention. Moreover, widening disparities due to the unequal distribution of health care and diverting resources from the poor to patients from abroad have formed the focus of those who oppose the medical tourism industry in developing countries.³¹

Apart from politico-economic aspects of medical tourism, there also exists a wide range of issues covered within the literature. Decision-making on the patients' side (quality of information, advertising and marketing), treatment processes (quality, safety, risk and patient satisfaction), medico-legal issues (liability, litigation, redress) and ethical dimensions have been addressed, albeit remaining scarce due to the lack of authoritative and reliable data.

²⁸ Tilman Ehrbeck, Ceani Guevara, Paul Mango, "Mapping the Market for Medical Travel" *The McKinsey Quarterly* (May 2008): 6.

²⁹ Devon M. Herrick, "Medical Tourism: Global Competition in Health Care" *National Center for Policy Analysis Report*, no. 304 (November 2007): 1.

³⁰ Hadi, 5.

³¹ Ibid

Globalization

The emergence and development of medical tourism has been enabled by globalization. Global economic and political structures have created a space for the expansion of the industry. Although the term globalization has overly been discussed in its own right with regard to its definition and extent, there exists a general consensus that it conveys a process generating transcontinental or inter-regional flows of interaction and activity.³²

It is characterized by four types of changes, all of which have partial influences in the emergence of medical tourism as a global industry. First, it designates a stretch in political, economic and social activities across frontiers, regions and continents. It involves intensification of interconnectedness and flows of trade, investment and finance. Also, the increasing intensity of global interconnectedness is linked to advances in transport and communication, which in turn enable the transmission of goods, information, capital and people. Finally the boundaries between domestic issues and global matters can become blurred. Briefly, globalization could be considered as widening and intensifying interconnectedness between all of the domains of human activity.

Medical tourism has developed in parallel with the flow of goods, capital, ideas and people which are facilitated by globalization. Hence, it is possible to argue that one of the main drivers of medical tourism is globalization in the domains of economy and culture. In this sense, the General Agreement on Trade in Services (GATS) and medical outsourcing will be assessed as part of economic liberalization, a

³² "What is Globalization?" <http://www.polity.co.uk/global/whatisglobalization.asp> [15 May 2015].

process connected to economic globalization. However, it is crucial to note that the expansion of the medical tourism industry has also acted as an intensifying factor of globalization. There exists a strong relationality between the growth of the industry and the globalization process. That is to say, medical tourism should be considered as a phenomenon which is both an actor and subject of globalization.

Cultural globalization, on the other hand, will be addressed as another driver of medical tourism. Advancements in technological tools and low-cost airlines have paved the way for familiarity with distant cultures, enabling cultural globalization.

Economic globalization is the integration and inter-dependence of national and international economies through increasing levels of movement of commodities, services, capital and labor. It has come to the forefront along with trans-national trade, which has grown over the last three decades. Institutions such as the World Trade Organization (WTO) have led the expansion through reducing trade barriers and opening up national markets to foreign investments. Developed economies, in this way, became integrated with the less developed economies. The restructuring of the world economy to the demands of liberalization hence occurred in such a framework.

Following the free flow of merchandise trade, services trade was enabled by GATS in 1995 after the Uruguay Round Negotiations. It provides the legal and legislative framework of the movements of certain services such as health, finance and telecommunication. The overall aim of GATS is to liberalize trade in services.³³ Countries make commitments in sectors in which they want to open up for foreign direct investment.

Direct trade in health-related goods, services, and people (patients and

³³ "General Agreement on Trade in Services (GATS)" <http://www.who.int/trade/glossary/story033/en/> [19 May 2015].

professionals) is provisioned under GATS. Medical tourism operates within the framework of four “modes” which regulate activities in different fields. Cross-border supply (tele health or laboratory services), consumption abroad (international movement for medical care), commercial presence (foreign investment in health facilities), and natural persons (temporary migration of health workers abroad) are the modes through which activities are regulated.

A country imports health care services when its patients travel abroad to receive treatment, which is regulated under “mode two” of services supply, as envisioned by GATS. In this regard, medical tourism is officially provisioned under GATS. Thus, medical tourism has become bureaucratized, formalized, and normalized by GATS provisions for the health sector.³⁴

Mode three (commercial presence), on the other hand, regulates an important area for the growth of the industry. It has created a space for investment in health care facilities. Globalization-led economic restructuring has expanded the inclusion of the private sector in health services in most of the developing countries, supplying and competing for local and international patients. This context has enabled an environment for the development of medical tourism as an international business opportunity in many developing countries. Given the fact that the health industry comprises a full range of services from medical equipment to pharmaceuticals, foreign investment could find promising areas through medical tourism.

Economic globalization also reveals itself in other forms as the free movement of services and people. A newly emerging practice of medical outsourcing is regarded as a significant element that boosts medical tourism. It has generated interest among

³⁴ Leigh Turner, "First World Health Care at Third World Prices: Globalization, Bioethics and Medical Tourism" *Biosocieties* 2, no. 3 (2007): 317.

large corporate sectors and legislatures of developed countries as a means of reducing the costs of health care.³⁵ Increasing numbers of companies, governments, and insurers appeal to medical tourism to lower health costs and maximize benefits.³⁶

Companies opt for outsourcing certain medical procedures for their employees since carrying out these procedures abroad has advantages in terms of cost, access and quality.³⁷ Smerd claims that some insurance companies in the United States send their clients to JCI-accredited hospitals in Thailand, Singapore, Turkey, Ireland and Costa Rica.³⁸ Also, Access Baja in California offers schemes that cover medical treatment abroad. Their plan provides a coverage option with lower premium and co-payments for employees of American employers who want access to health services in Mexico. US Senate Hearings implied that West Virginia's legislative in 2006 and three Fortune 500 Companies conducted some work to promote traveling to developing countries for health.³⁹

Deloitte's 2009 medical tourism industry report cited four US health insurers that were planning reimbursement for elective procedures, which consists of surgeries that do not require medical emergency and are scheduled in advance, in Thailand,

³⁵ Daniel Yi, 30 July 2006, "US employers look offshore for health care," <http://truth-out.org/archive/component/k2/item/64504:us-employers-look-offshore-for-health-care> [8 May 2015].

³⁶ Brent McCallum, Philip Jacoby, "Medical Outsourcing: Reducing Clients' Health Care Risks" *The Journal of Financial Planning* 20, no. 10 (2007): 31.

³⁷ Rory Johnston, Valorie Crooks, Jeremy Synder, Paul Kingsbury, "What Is Known About the Effects of Medical Tourism in Destination and Departure Countries? A Scoping Review" *International Journal for Equity in Health* 9, no. 24 (2010): 7.

³⁸ Jeremy Smerd, "Large Companies Hopping Aboard Medical Tourism" *Workforce Management* 87, no. 11 (2008): 8.

³⁹ Seyfettin Erdogan, Emine Yılmaz, "Medical Tourism: An Assessment on Turkey" (Presentation, 10th International Conference on Knowledge, Economy and Management, İstanbul, November 8-10, (2010).

India, and Mexico. The reason for the growing demand to health services in developing countries arises from lower labor costs, the availability of inexpensive pharmaceuticals, and the low cost or malpractice insurances.⁴⁰ Some procedures are offered at 10 percent of the cost in the US, including travel and accommodation.

In addition, the diasporic component of medical tourism seems to be on the rise for both insurance companies and hospitals. Some places such as Juarez in Mexico are aiming to target the migrant population living outside the country, especially in the US.⁴¹ Such instances also occur in Turkey, to which a large group migrants who live abroad prefer to return to their home country to receive medical treatment through bilateral social security agreements made between governments. These examples demonstrate how flow of global capital and people have given rise to the expansion of medical tourism activities. Although the industry involves risks of incidents that require legal proceedings, medical tourists and service providers appear to be more concerned with the costs and returns.

After mentioning the impact of the economic globalization on the development of medical tourism industry, it is crucial to discuss cultural globalization as a process that facilitated familiarity with distant cultures. Although the term “cultural globalization” may have negative connotations in its theoretical discussions, in this thesis it is defined as the intensification of social relations through the transfer of ideas, values, perceptions, and meanings.

The process has been enabled by the increasing involvement of technological

⁴⁰ Andrzej Tucki, Paul Cleave, "Medical Tourism-New Growing Industry on a Concealed Market" *European Journal of Medical Technologies* 4, no. 5 (2014): 3.

⁴¹ Regan Bergmark, Donald Barr, Ronald Garcia, "Mexican Immigrants in the US Living Far from the Border may Return to Mexico for Health Services" *Journal of Immigrant and Minority Health* 12, (2008): 612.

tools in daily life as well as low-cost airline travel. The use of the Internet and media materials has helped patients in two ways. Primarily, they are able to learn about other countries and their cultures, which renders cultural familiarity possible, and they are able to gather information about overseas health services.

The same is true for low-cost airlines. People can travel to other countries with inexpensive airline tickets, developing a sense of familiarity, which can be regarded as part of cultural globalization. Moreover, patients are given significant discounts on the condition that they travel as medical tourists.

Technological progressions and low-cost air travels have contributed to the growth of medical tourism as both enabler and facilitator. They have assumed an important role in the development of medical tourism as familiarity is one of the basic drivers behind the industry. Glinoz et al. identify familiarity as one of the crucial factors in choosing medical tourism destination, alongside availability, cost, quality and bio-ethical legislation (abortion services, fertility treatment and euthanasia services).⁴² In this sense, cultural globalization, by providing familiarity with different cultures can be regarded as one of the factors that has helped medical tourism expand.

Transformation in Healthcare Systems

The expansion of medical tourism has developed in parallel to the transformations in healthcare systems. The factors that gave way to the growth of the industry have been partially induced by these transformations. It is therefore crucial to

⁴² Irene Glinoz, Rita Baeten, Nicole Boffin, "Cross-border Contracted Care in Belgian Hospitals" in *Patient mobility in the European Union: learning from experience*, ed. Magdelene Rosenmüller, Rita Baeten, Martin McKee. European Observatory on Health Systems and Policies (2010): 128.

comprehend the ways in which medical tourism could relate to the changes in health systems that have remained on the agenda since late 1980s.

Health systems have witnessed important system level changes in the last three decades. The questioning of the responsibility of states to provide basic services such as health has come to the forefront with the restructuring of the world economy to neo-liberal impositions. Such inquiries have brought about the liberalization of healthcare services, which has been marked by increasing levels of private mechanisms in health.

Along with the relative withdrawal of the state from the provision of health care, the private sector has found an opportunity to acquire a stronger position vis-à-vis public hospitals in providing health services. Medical tourism has expanded in such a context, where states strive to limit health expenses on budgets and the health industry has gained a profit-generating character.

Healthcare reforms should be assessed from a broad perspective, and in their relation to welfare system debates. Since the late 1980s, a series of attempts to reform welfare systems have been introduced. These attempts indicated a tendency to redefine and transform the relationship between the state, market and family.⁴³

The primary driver behind such reforms has been to reduce public expenditure and to increase productivity. Increasing the costs of health services, caused by aging populations and longer life expectancies, has put increasing burdens on governments. This could be regarded as the primary driver which has pushed regimes to system-level policy changes towards contracting health budgets.

The beginning of the neo-liberal era was marked by the understanding of limiting public expenditures as far as possible. The decline of welfare states coincided

⁴³ Tuğba Ağartan, "Sağlıkta Reform Salgını", in *Avrupa'da ve Türkiye'de Sağlık Politikaları* ed. Çağlar Keyder, Nazan Üstündağ, Tuğba Ağartan, Çağrı Yoltar (İletişim: İstanbul, 2011): 38.

with this period, in an environment where large scale economic upheavals took place. The economic crises of the 1970s and the collapse of the Bretton Woods system were portents of an economic bottleneck which triggered the decline of welfare systems.

It is also crucial to emphasize that there occurred a shift from Fordism to post-Fordist production which enabled the expansion of the services sector. As industrial employment decreased, irregular and flexible employment appeared as new forms of employment. This created a widespread concern for social security institutions as they were primarily funded by premiums and taxes collected from formal employees.

Health, on the other hand, emerged as a significant service sector. Aging populations and low birth rates induced an increase in the healthcare expenses of developed countries. These demographic components forced governments to restrict social security expenditures within the framework of the Maastricht Agreement and the European Monetary Union.⁴⁴ Institutional-level restrictions have also been implemented in developing countries since the early 1980s. The IMF and the World Bank demanded certain adjustment policies in South America, Southeastern Europe and Africa. Macroeconomic policies dictated by such international bodies envisioned a decrease in social expenditures in these countries.

Along with the system level changes, ideological factors played a crucial role in the withdrawal of state from basic services provision. The Keynesian understanding was replaced by neo-conservatism, which portrayed public services as inefficient and of poor quality.⁴⁵ The role of the state in welfare provision was criticized. Thus, market mechanisms attained a greater role in sustaining these services. In this respect, it was

⁴⁴ Ibid., 40.

⁴⁵ Ibid., 42.

believed that welfare services could be better provided by the market. Global organizations such as the OECD, the WHO and the World Bank assumed crucial roles in the expansion of such practices.

Demographic changes, neo-liberal impositions in the economy, and advances in medical technologies have brought about large-scale health reforms in most of the developing countries, more or less comprised of similar measures. Global reform packages consisted of the restructuring of social security contents, separation of finance and provision, promoting market mechanisms, and decentralization. The extent and implementation of these measures varied in accordance with the economic and political dynamics of a given country. However, it is important to note that the ongoing efforts to transform the healthcare systems were actualized on the grounds of limiting public expenditures.

The overall purpose of the transformations in health systems was to reduce social expenditures. Hence, the role of the state in welfare provision was meant to be limited. To this end, some other measures were put into practice within the broader perspective of marketization tendencies.

Hospital management was transferred to professional managers, public financing started purchasing health services both from public and private hospitals, and efforts were made to establish a family medicine system. Moreover, additional payment was put forward to create resource and restrain from unnecessary utilization. These measures were taken to strengthen the already established premium-based health systems.

The opening up of health services to private forces created a highly profitable investment areas for investors. Pharmaceuticals and health technology are among the popular industries that promise significant growth rates, especially in developing

countries. Governments and private companies act in coordination to highlight the industrial facet of health services.

Although medical tourism is regarded as a recent phenomenon, the factors that triggered its growth are a result of long-lasting, structural transformations. The shift to neo-liberal economic policies and relative weakening of welfare states constituted the basis upon which there occurred a need to transform healthcare systems.

As the role of the state in welfare provision was restricted due to budgetary concerns, private mechanisms attained a greater share in the services delivery. Thus, medical tourism emerged as a sustenance for the developed world where states fell short of providing certain services in a short span of time.

Developing countries, on the other hand, institutionalized medical tourism as an income-generating industry. Given the economic and political factors that have been influential in the growth of the industry, it is possible to regard medical tourism as a component of the broader health system transformations.

In the next chapter, transformation of Turkish healthcare system will be elaborated from a historical perspective, touching upon welfare and health system models. With a view to reveal the relationship between the expansion of medical tourism industry and health system changes, the Healthcare Transformation Program will be addressed.

CHAPTER 3

THE TRANSFORMATION OF THE TURKISH HEALTHCARE SYSTEM IN RELATION TO MEDICAL TOURISM INDUSTRY

Chapter 3 discusses the character of the Turkish welfare regime and healthcare system in order to better grasp the ever-changing debates on health. In order to provide a comprehensive theoretical framework, a concise discussion on welfare regimes and health systems will be given. Then, the basic developments in the Turkish healthcare system will be analyzed historically with particular attention to the Health Transformation Program in its relation to the growth of medical tourism industry.

Medical tourism in Turkey has attracted significant attention in recent years. Given the potential growth rates of the industry and the expected rise in healthcare expenses, policy makers strive to make Turkey an important hub for medical tourism facilities.

There have been major alterations in the domains of health and trade on which medical tourism is positioned. Policy changes in these domains have been induced by the economic and social forces that have shaped the global economy since the 1980s. The changing nature of the welfare systems and the expansion of free market economy have paved the way for the growth of medical tourism industry. Such structural changes also have necessitated a comprehensive transformation in the healthcare system in Turkey, which has received considerable scholarly attention.⁴⁶

⁴⁶ For a full discussion on Turkish healthcare system, see Ayşen Bulut, *Türkiye'de Sağlık Reformunun Tarihçesi* (İstanbul: İletişim, 2007); Asena Günel, *Health and Citizenship in Republican Turkey: An Analysis of the Socialization Services in Republican Historical Context*; and Volkan Yılmaz, *Changing Form of Inequality in Access to Health Care in Turkey (New Perspectives on Turkey 48, 2013)*.

The establishment and development of the medical tourism sector in Turkey have been rendered possible with the changes brought about by the Healthcare Transformation Program initiated in 2003. It is therefore crucial to understand how the transformation of healthcare services and the growth of medical tourism constitute an umbilical relationship.

Types of Welfare Regimes and the Turkish Healthcare System

Health is an important element of analysis in the area of social policy. It partially designates the character of welfare states and the degree to which states assume role in the protection and well-being of its individuals.

Welfare debates are basically constructed upon the concept of citizenship. According to T. H. Marshall, citizenship is a status given the full members of the community who are equal in terms of rights and duties.⁴⁷ He argues that the development of citizenship is bounded to the development of social, political, and civil rights. In this respect, social rights are composed of economic welfare and security which constitute an essential portion of an individual's well-being. Political rights, on the other hand, indicate participating in the exercise of political power. The parliaments and local governments are considered authorities in the pursuance of political necessities.⁴⁸ Civil rights denote a more judicial perspective, implying the rights for individual freedom and the right to justice.⁴⁹

⁴⁷ Thomas H. Marshall, "Citizenship and Social Class" in *Class, Citizenship and Social Development: Essays by T. H. Marshall*, (Garden City, New York: Doubleday and Company, 1964): 72.

⁴⁸ Ibid. 149.

⁴⁹ Ibid. 148.

The notion of social rights and citizenship are in close relationship with welfare state debates as these two components can be seen as the basis upon which welfare regimes are constructed. At this point, Esping-Anderson identifies three distinct types of regimes in advanced capitalist democracies, all of which have different organization and stratification. These regimes are social democratic, conservative, and liberal welfare states. Although highly criticized for its failure to cover all aspects of welfare regimes, the typology is still an important tool in analyzing the role of state, market and family in welfare provision.

The elements of family, state, and market and their varying involvement in the procurement of certain welfare services are crucial in determining the characteristics of welfare regimes.

The social democratic welfare regime is based on citizenship where reliance on family and market is limited to a large extent. The state assumes responsibility for basic services, such as healthcare and education. The principles of universalism and equality shape the organization of the regime. Scandinavian countries such as Norway and Sweden are prominent examples of social democratic welfare state model.

In the conservative regime, social insurance schemes play an influential role in the provision of services. In accordance with the employment based social insurance schemes, there exists a high degree of social stratification. According to Esping-Anderson, the welfare is used to maintain class and status divisions and provide loyalty to the state, as civil servants benefit from most public and high standard services. The traditional family is strong in terms of ensuring basic safety nets to its members. France, Germany, and Austria could be regarded as important cases of the conservative welfare regime.

The liberal welfare regime, on the other hand, is based on market-based social

insurance and private provision, where state interferes on a means-tested basis to provide the basic needs of the poor. Bauman argues that such means-testing mechanisms create discrimination and stigmatization against the poor. He further claims that inclusionary and universalist approaches, as opposed to exclusionary attitudes in service provision, enhance the social integration and sense of community. The level of social stratification is also high in the liberal welfare states such as the US, Australia, and Canada.

Esping-Anderson has been criticized for categorizing Mediterranean countries as a subgroup of the conservative welfare regime. He claims that the economies of Southern European countries (i.e. Spain, Italy, Greece, Portugal) are in transition toward eventually attainin the structure of the welfare regimes of the continental European counterparts. However, the critics of Esping-Andersen's welfare typology put forward the idea that Southern European countries fall into a different type of regime since the economic organization in those countries display a different structure.

Ferrera claims that the transition to Fordism in Southern European countries has created serious exclusions from formal employment, and in turn from social insurance benefits, in an economy which was mainly formed of agriculture and self-employment.⁵⁰ Exclusion from formal economic activities created high levels of informality in the economy.

Along with a large informal sector, the presence of family as the major safety net and lack of state dominance in welfare provision distinguish Southern European countries from their continental European counterparts. However, the social insurance scheme based on employment-status in southern countries corresponds to the system in

⁵⁰ Maurizio Ferrera, *Welfare State Reform in Southern Europe: Fighting Poverty and Social Exclusion in Italy, Spain, Portugal and Greece* (London; New York: Routledge, 2005): 5.

the conservative welfare regime, which eventually calls in family support due to its very structure, which excludes informal labor.

As discussed above, health is a significant element in analyzing welfare regimes. Although most healthcare systems have been organized in accordance with the peculiarities of their related welfare regimes, some healthcare systems display discrepancies. The critical aspect in healthcare systems is the way through which they are financed. States might assume greater responsibility in the provision of healthcare and finance health services through taxation. Or, market forces hold greater share and health could be regarded as the responsibility of the individual. In this respect, it is possible to talk about three types of healthcare systems in which public finance has a variant role.

The first one is the national health system, where health services are provided to all citizens regardless of their employment status, which demonstrates its universalistic approach based on citizenship. Social democratic welfare regimes like Norway and Sweden have adopted this healthcare system in line with the principles of their welfare regime.

Second, the social insurance system, which is also known as the Bismarckian model, has high levels of social stratification in terms of healthcare services. Healthcare in this model is financed through premiums paid by the employees and employers and excludes those who are in the informal economy. Germany could be shown as a case for the Bismarckian model.

The third model is the private insurance system where the share of the market is quite high. In this model, state intervenes in the provision of healthcare for the poor and elderly, leaving others unprotected in the market. The US could be shown as a case for the private insurance system.

As mentioned above, healthcare systems do not necessarily coincide with the characteristics of a given welfare regime. Countries such as Great Britain, Canada, and Italy have health systems that are different from the features of their established welfare models. Canada and Great Britain have adopted national health services even though they fall into the group of liberal welfare regime. Italy, on the other hand, also has a national health system although it is classified as a conservative welfare state.

Other Southern European countries such as Greece, Spain and Portugal have national health systems as well, which call for a different classification of welfare regime for these countries. It is important to note that there exists no ideal form of healthcare systems as all health systems are complex in nature and organization. It is appropriate to evaluate healthcare systems across a range of categories rather than designating them as distinct categories.

The Turkish welfare regime, which has received notable academic interest,⁵¹ follows certain aspects of the conservative model in regard to its social insurance model. The employment-status based model, as prevailing in countries such as Germany, was dominant until 2003. The necessity of being a formal employer in order to benefit from healthcare services created serious problems due to the high level of informal activity. This very aspect of informal economy causes dependency on family, a feature that is also prevalent in Southern European countries.

The strong role of the family and large informal economy are two important factors that determine the welfare regime in Turkey. The share of the role between state, market and family is shaped around these two structural determinants.

⁵¹ For a full discussion on the Turkish welfare regime, see Ayşe Buğra, "Türkiye'nin Değişen Refah Rejimi: Neoliberalizm, Kültürel Muhafazakarlık ve Yeniden Tanımlanan Toplumsal Dayanışma," in Türkiye'de Refah Devleti ve Kadın, ed. Saniye Dedeoğlu and Adem Yavuz Elveren (İstanbul: İletişim, 2012), 47-67.

The Turkish healthcare system, has never displayed an inclusive character. It has comprised features from both national health system and social insurance models since the establishment of the socialization of healthcare services law in 1961. From that time, a series of changes concerning the health system has been introduced to the existing laws depending upon the welfare approach of governments. Although health was considered as a right to be provided by the state in the law of 1961, social insurance schemes created problems in practice. In other words, efforts were made to provide an equal and efficient health system in the 1960s, yet employment-based insurance scheme created inequality among the different stratas of society.

With the Health Transformation Program initiated in 2003, all components of the social insurance system were united under one social security institution. By abolishing the hierarchy among social security institutions, an inclusive model that entitled citizens to benefit from public hospitals regardless of their employment status was aimed to be established. Yet, this model has fallen short of ensuring health as a citizen right due to its failure to cover informal sector workers.

Considering the high levels of informal activity in Turkey, to what extent the new system will provide efficient and equitable access to its citizens will remain ambiguous until some structural changes are introduced.

Developments in Healthcare Policies between 1960-2000

The Turkish healthcare system has never had an integrated and consistent structure. It has embraced different policies depending upon the welfare approach of governments. Economic policies of the day were also substantial in shaping the character of the Turkish health system. In the pre-JDP (Justice and Development Party)

period starting from 1960, it is possible to speak of two distinct periods in which state undertook different roles in the provision of healthcare.

In the 1960-1980 era, the state played an extensive role in social policy issues. However, starting in the early 1980s, it is possible to talk about relative resignation of the state and gradual inclusion of market forces in health services. It is important to address these two periods separately in order to grasp the differences.

After 1945, some important measures were taken to build a sufficient social security institution, albeit progressing slowly and often interrupted. Together with the establishment of the Ministry of Labor in 1945, the agenda shaped around the issues of labor and occupational safety.⁵² Then, the law on Industrial Accidents, Occupational Diseases and Maternal Security (no. 4772) was issued in 1945. The Labor Institution (law no. 4792) was established in 1946.⁵³ The same year, the Law on Social Insurance Institution (no. 506) entered into force, putting together all other laws (The Old Age Insurance Law-1949, the Illness and Maternal Insurance Law-1950, Disability, Old Age and Death Insurance Law-1957) concerning workers, pensioners, and their families.

In 1949, the Retirement Fund Law (no. 5434) was accepted for regulating the social insurance rights of the civil servants who work at the public sector, by abolishing all existing small-scale civil servant funds.⁵⁴ This law, which came into force in 1950, also provided social security to military personnel. Although these attempts were crucial, they applied to only a small portion of the population. The

⁵² Nadir Özbek, *Cumhuriyet Türkiye'sinde Sosyal Güvenlik ve Sosyal Politikalar* (İstanbul: Emeklilik Gözetim Merkezi -Tarih Vakfı, 2006): 159.

⁵³ Republic of Turkey, *T.C. Resmi Gazete*, no. 4792, 16 July 1945.

⁵⁴ Republic of Turkey, *T.C. Resmi Gazete*, no. 5434, 17 July 1949.

majority of the workers in industry and peasants, who comprised 80 percent of the population, remained uncovered. Only those who were formally employed were covered within the social security framework until the 1970s.

Concepts like social right and social insurance gained a constitutional essence with the 1961 Constitution. The issue of social security and the duty of the state to provide this right were thoroughly addressed in the 1961 Constitution by the National Union Committee, which carried out the 1961 coup d'état. Health was regarded as a right and an attempt was made to implement a citizenship-based healthcare system. In accordance with the social state understanding of the era, the state assumed responsibility to provide social security for the whole population by embracing inclusionary policies towards workers and peasants.

With such measures, the scope of the welfare model gained a more inclusive character and the population covered by a security scheme expanded in the 1960s and 1970s. Considering the provisions put forward by the new constitution, the Social Security Institution of Craftsmen, Tradesman and Other Self-Employed (*Bağ-Kur*) was established in 1971 (law no. 1479) to enable the self-employed benefit from social security services. However, those who worked at the agricultural sector had to wait until 1983 to be included in the Bağ-Kur coverage of social security.

The fragmented nature of health services in Turkey also revealed itself in the provision of services. Due to the excess demand on public healthcare facilities, the Social Security Institution (SSK) built its own hospitals by the law as envisaged in the Social Insurance Law of 1964. The insurers of the Retirement Fund (*Emekli Sandığı*) and Bağ-Kur, on the other hand, benefited from the hospitals of the Ministry of Health and university institutions. There was also important discrepancies between the premium rates paid by the insurers of different institutions, benefit packages, and

additional payments collected on a conditional basis.

Considering the demographic structure of the country, a series of measures were put into practice in order to resolve the disparities between regions. The Socialization Law (no. 224), which was accepted in 1961, aimed to provide health services on an equal basis.⁵⁵ The initiation of the socialization services in the underdeveloped regions reflects the concerns of the National Union Committee's about social justice. Their efforts to constitute a system based on a universalistic welfare model relied mostly on their recognition of the National Health System in Britain.

The idea of referral chain was also prominent in the Socialization Law. Patients were required to consult a first level health practitioner and could be sent to a health center or hospital if deemed necessary. Those who do not adhere to the practice of referral chain had to pay for the treatment out of pocket. The main purpose of the referral chain was to prevent overcrowding of hospitals and to minimize redundant spending. Providing basic health service to all people via primary care units also served the objective of the efficient utilization of hospitals.

The implementation of the program, however, did not proceed as planned. One important reason was the inadequate number of health personnel, which was mainly caused by the failure of laws encouraging doctors to work in remote areas. The lack of strong planning and limited resources of the following civilian governments could be regarded as other crucial reasons that left the program without being fully realized.

Günel argues that the main reason for the failure to establish a universal health care system in Turkey was the prevailing inegalitarian corporatist welfare regime

⁵⁵ Republic of Turkey, *T.C. Resmi Gazete*, no. 224, 12 January 1961.

which was based on status membership.⁵⁶ The inegalitarian corporatist aspect of the state incorporates the employment-based security system with a large informal sector.

As previously discussed, the Turkish model designates features from both conservative (corporatist) and Southern European welfare regimes. The fragmentation of health insurance among different institutions clearly demonstrates the hierarchical nature of the Turkish health systems since the quality and coverage provided by these institutions varied in no small measure.

The 1980s was marked by marketization incentives and the gradual inclusion of market forces into service provision. The failure to establish a universal health system due to various reasons was merged with liberalization tendencies of the day.

It is also important to consider the high levels of informal activity, which left large portions of the population without any social insurance. The problems that caused the failure of the system still persisted, while taking on another dimension; urbanization. Günel asserts that the emphasis of the governments after the 1980s shifted from bringing basic health care to peasant citizens to bring it to the urban population.⁵⁷

General health insurance was still on the agenda, along with some structural changes to the organization of health care services. Family medicine, decentralization in health services, autonomization (*özerkleşme*) of hospitals towards privatization, and promotion of the private sector came to the forefront of the health policies of the following governments.

Budget deficits in social insurance schemes caused by increasing health costs

⁵⁶ Günel, 279.

⁵⁷ Ibid., 390.

necessitated radical alterations. The requirements for the transformation were substantially dictated by the World Bank and the International Monetary Fund (IMF), whose intervention became prominent in this era. Issues like the separation of provision and finance, decentralization, the involvement of non-public institutions, and the increasing role of market mechanisms were put into implementation by the proposals of the World Bank.

Market forces were regarded essential in regard to the structural problems prevailing in most fields, especially in healthcare. However, regional disparities and large portions of the population with no means were ignored. The Motherland Party (*Anavatan Partisi*), which was the bearer and an ardent advocate of the neo-liberal transformations in the 1980s, used public resources to support private healthcare and forced hospitals to generate their own resources. The privatization of health came with the administering of hospitals on a private business model.

It is also important to assess the shift in the economic policies of the day on the grounds that marketization strategies in healthcare came with the need to transform the economic restructuring. The liberal economic policies adopted by the Özal government were signs of economic globalization that brought increasing levels of interdependency among economies.

The import-substitution model of the pre-1980 period in Turkey was based upon import prohibition and a high customs wall to ensure the reserve of foreign exchange. However, national developmentalism proved to be inefficient. The shift from the planned economy to liberal restructuring started in the early 1980s, which brought about radical changes in the understanding of competition and liberalization.

As with the opening of national economy to foreign investment, the role of the state in welfare provision started to diminish while market forces took a bigger share.

On the other hand, the Özal governments (1983-1987, 1987-1989) supported general health insurance along with preventive care, equal distribution of health personnel, hospitals and centers. Their emphasis on general health services came with the increasing share of private hospitals which would diminish the role of the Ministry of Health and Social Security Institution (SSK) hospitals.

Along with the emphasis on privatization and decentralization, the World Bank also put forward the necessity of equality in access to basic services. In line with the proposals of the World Bank, regional discrepancies and general health insurance were important issues that were addressed in the social policies of the following governments. Yet, the establishment of a social security system based on citizenship right could not be improved in the 1990s due to the very nature of status-based model that distinguish citizens among occupational stratas. Those who were not covered by any social insurance scheme started to experience serious problems in terms of reaching basic health services.

The Turkish National Health Policy was published by the Ministry of Health in 1990, embracing the coverage of excluded 24 million citizens as an urgent task.⁵⁸ The establishment of a family medicine system and the improvement in the distribution of health personnel were set as other important goals. The mechanism of a referral chain was emphasized for the purpose of efficient use of hospitals. Also, hospitals would be given autonomous character. The major components of the health reforms starting with the 1990s could be identified as family medicine system and general health insurance.

The World Bank was an important supporter and the financier of the projects

⁵⁸ “2000 Yılında Herkese Sağlık: Türkiye Milli Sağlık Politikası” (Ankara: T. C. Sağlık Bakanlığı, 1990).

that were conducted in the 1990s. Along with the family medicine and general health insurance proposals, the World Bank also underlined the importance of the autonomization and privatization of hospitals for a developed health system. With the involvement of the private sector in service provision, the role of the Ministry of Health was planned to diminish.

As hospitals were forced to cover their expenses through the revolving funds, the fees collected from patients rose in significant numbers. The Özal governments' support for increasing the share of private service provision and the prevailing inegalitarian structure of the social insurance system created high levels of displeasure among the poor and informal sector workers. A new measure was put into effect by the coalition government of True Path Party (*Doğru Yol Partisi*) and Social Democratic Populist Party (*Sosyal Demokrat Halkçı Parti*) in 1992.

The establishment of a system which operated on a means-testing basis was put forward to provide basic services to the poor. The Green Card Scheme (*Yeşil Kart*) was designated for those whose monthly income was less than one-third of the net minimum wage.⁵⁹ The expansion of the healthcare gained an important dimension with the introduction of the Green Card scheme. However, it is important to note that since there existed a means-testing mechanism rather than a citizenship-based health service, the corporatist structure of the Turkish model was not fully challenged.

Developments in the healthcare coverage provided to the poor, along with increasing commercialization and privatization practices changed the scope of Turkish healthcare in the 1990s. Despite some improvement efforts, the weak coalition governments of the 1990s failed to carry out important outcomes to strengthen health

⁵⁹ Republic of Turkey, *T.C. Resmi Gazete*, no. 3816, 13 August 1992.

services. High inflation and fiscal crises hindered governments from applying substantial policies.

Developments in healthcare on the global scale displayed no difference in reference to provision, finance, and regulation. After the 1990s, healthcare coverage constituted one of the major concern for the developing world as most of the international aid programs focus on increasing the reach of health services. The separation of finance and provision, decentralization, and the increasing role of market mechanisms in service provision were much pronounced in the reports of international organizations for developing countries.

In order to avoid redundant spending in hospitals and health centers, primary care and preventive mechanism have been put forward. Social security institutions were designed to purchase service from public and private providers. Besides, a control mechanism on providers' practices assumed by the regulatory body, which is the state in this context, was planned. Ağartan implies that the role of the state was delimited to finance and regulation, whereas private sector and contract-based doctors undertook the provision facet of health provision.⁶⁰

In the 1990s, a series of policies were performed in order to improve the health status of citizens and to close the unequal distribution gap of health services. The General Health Insurance scheme was constantly addressed by different governments, albeit eschewing from intervening in the inegalitarian corporatist structure of the health system which was composed of hierarchical security institutions.

As seen, during the 1960-1980 period, health was defined as a service that should be provided by the state. The social security policies embraced in the era were

⁶⁰ Tugba Ağartan, "Health Sector Reform in Turkey: Old Policies, New Politics" (Presentation, Annual Meeting of the Midwest Political Association, Chicago, 7-10 April, 2005).

in accordance with the welfare understanding of the 1961 Constitution. However, the 1980s marks a new era in which commercialization tendencies of the government created drastic results for the welfare character of the state. The efficiency of the health system was in crisis and some other measures were needed.

The Green Card scheme brought a certain degree of relief to the poor, which was an important yet inadequate mechanism. Due to the economic bottleneck in the 1990s, no substantial change could be brought into practice.

Changing Scope of the Turkish Health System in the 2000s:

Healthcare Transformation Program

The JDP came to power in 2002 in an environment of optimism where public discontent was high with the increasing rates of inflation and inconsistent coalition governments. The promised economic improvements were priority issues of the newly elected political party.

In the aftermath of the economic crisis of 2001, the Turkish economy once again turned to the IMF and the World Bank for financial support. Accordingly, economic policies followed by the JDP were in coherence with the suggestions put by these institutions. On the other hand, the fact that JDP came to power without the support of a coalition partner served its eagerness to realize radical changes in many areas of the economy and social policy, including healthcare services.

The Health Transformation Program of 2003 mainly aimed at providing accessible, sustainable, and qualified healthcare services to all citizens in an efficient, productive and equitable manner.⁶¹ The problems and solutions that were addressed

⁶¹ "Sağlıkta Dönüşüm Programı" (Ankara: T. C. Sağlık Bakanlığı, 2003): 26

are not much different than the previous policy reports.

At the beginning of the 2000s, 19 percent of the population lacked social insurance coverage.⁶² The number of Green Card holders was 13 million. Although there were substantial efforts to reach high numbers of people under the Green Card scheme, one-fifth of the population still had no health insurance. Sixty percent of Bağ-Kur members could not pay their premiums due to their inconstant incomes. There was also high dissatisfaction among the covered members of social security. SSK members mostly complained about the time they spent in long queues to get treatment, whereas Bağ-Kur members had problems in accessing certain health services. High rates of inequality in terms of quantity and quality were persistent in the health insurance system.

Growing disparity could also be understood from the per-capita cost of insurance schemes. In 2000, it was around \$56 for Green Card, \$110 for SSK members, \$148 for Bağ-Kur, \$210 for active civil servants and \$290 for the Retirement Fund.

The main financiers of healthcare services in 2003 were social security institutions and the state, 50 percent and 48 percent, respectively. The share of the state was distributed between the Ministry of Health, Green Card, civil servants, and social health insurance schemes, in unequal numbers. In addition to the intricate financial structure of these institutions, distribution of health personnel among regions created serious problems. On the grounds of unequal financial and organizational set-up of the prevailing health system, Turkey ranked behind most middle-income countries in health indicators in OECD reports.⁶³

⁶² Günel, 454.

The solutions proposed to the inefficient functioning of the health system in Turkey by the JDP government contained many similarities to those of the previous governments. A strong family medicine, well-developed referral chain, autonomization of hospitals and general health insurance had been on the agenda since the late 1980s.

Considering the socio-economic status of its voters, it could be argued that the JDP gained popular support with its health reform proposals. It took almost five years to prepare the draft bill of the program. The Ministry of Labor and Social Security worked in close cooperation with other institutions to make the necessary legislation within the framework of the Transformation Program.

The Social Security Institution was established in 2006, and the implementation of the Social Security and General Health Insurance Law started in 2008. The latency of the commencement could be explained with the resistance of civil servants and labor unions. Moreover, the Constitutional Court annulled some of the articles in the Social Security and General Health Insurance Law in 2006.⁶⁴ It could be evaluated on the basis that there existed bureaucratic resistance to preserve the favored position of civil servants in the welfare system.

The program envisioned radical changes in the organization, financing and provision of healthcare services. It is possible to identify these attempts as restructuring of the Ministry of Health, a general health insurance system that unified all existing social security schemes under one institution, financial and administrative autonomization of hospitals and family medicine for the purpose of primary care and strengthening of the referral chain.

⁶³ Turkey: Joint Poverty Assessment Report: Poverty Policy Recommendations 2, (Washington DC: World Bank, 2005): 74.

⁶⁴ Republic of Turkey, *T.C. Resmi Gazete*, no. 5502, 20 May 2006.

As mentioned above, the Ministry of Health was involved in the provision and financing of healthcare services. Along with the new legislative changes, the duties of this institution was limited to regulation and monitoring.

In the Health Transformation Program, it is underlined that the Ministry of Health was incapable of developing policies and leading the sector since it struggled with the administrative duties of its institutions. The idea of decentralization and autonomization of hospitals gained prominence at this point. Hospitals were entailed to have administrative and financial autonomy which would be governed by managers rather than high ranking health personnel. However, this could not be fully implemented.

Also, an agency to manage health insurance funds, Social Security Institution, was founded. The role of financing was aimed to be basically performed through this agency. Instead of a fragmented social security scheme which was composed of SSK, the Retirement Fund, Bağ-Kur and Green Card, General Health Insurance was established for the purpose of equal scope and quality.

In this respect, one can argue that the corporatist, inegalitarian nature of the Turkish healthcare model gained a more inclusionary character. Those who had no means to pay premiums were subject to a means-testing mechanism and their premiums were to be paid by the State. In this regard, it differs from the Green Card scheme in a way that it is not based upon a hierarchical structure established on employment status. Moreover, private insurance was promoted on the condition of being involved in the General Health Insurance.

On the other hand, efforts were made to re-institutionalize public hospitals to act as private providers, with a managerial rationality, in the sector by minimizing costs and increasing profits. Regardless of their status, public and private hospitals

were encouraged to improve their performance and patients were given right to choose their doctors.

Together with autonomization of hospitals, a split between purchaser and provider was originated. Hospitals would become autonomous bodies which provide healthcare services, and General Health Insurance Institution would purchase health services from providers. Autonomization, at this instance, could be defined as transformation of public benefit institutions into commercial bodies, albeit as non-profit corporations.

Family medicine was promoted for the purpose of improving primary care which in turn would prevent crowding at hospitals and redundant healthcare expenses. Family doctors were to be employed on a contractual basis. The discipline of family medicine at medical schools was to be improved.

Another important point about the newly-transformed health system is that the state makes 5 percent contribution in disability, old age and death insurance and three percent for General Health Insurance. In the former system, the state made no contribution to premiums and its role was limited to covering the expenses of civil servants and Green Card holders.

Given all the changes brought about in the organization, the finance and provision aspects of the Health Transformation Program, some scholars draw attention to the financial sustainability of the system. Healthcare spending increased to 32 billion TL in 2010, which indicates an eightfold increase in nine years.⁶⁵ Also, the expenses of Green Card holders increased in great numbers.

⁶⁵ "Sağlık Harcamaları Yıllık Katlanarak Artıyor," 9 May 2011, <http://www.kamudanhaberler.com/haber/saglik/saglik-harcamalari-yillik-katlanarak-artiyor/3948.html> [7 May 2015].

In 2013, almost 79 percent of health expenses were covered from the state budget.⁶⁶ Spending on ambulatory care and medical equipment composed the highest portion of health expenses in 2013, 13.6 percent and 25.8 percent, respectively. Besides these, the established premium-based system falls short of providing necessary financing as stable employment could not be achieved due to the flexible character of the market. High rates of informal economic activity should also be given emphasis in understanding the structure of premium-base model of healthcare services.

Apart from debates about financial sustainability, there are other issues that need to be pointed out within the framework of the Transformation Program. A series of criticisms were brought forward for marketization tendencies of the JDP governments. It is argued that efforts were made to incorporate the egalitarian character of public services with the productive character of the private sector under public-private partnership model. Therefore, issues like contractual employment, competition and consumer choice came to attract much attention within policy-making processes.

The contractual employment basis reflects itself upon the purchaser/provider split. With the institutionalization of the Social Security Institution as the sole purchaser of healthcare services, and hospitals as the providers, contractual relationship, which is an important aspect of market relations, was actualized.

The idea of the decentralization of hospitals contributed to the process as competition and consumer choice are regarded as prominent aspects of the transformation process. Critics claim that there was a tendency to create a healthcare market which started with the public/private split and followed by the commoditization

⁶⁶ "Sağlık Harcamaları İstatistikleri 2013," 5 November 2014, <http://www.tuik.gov.tr/PreHaberBultenleri.do?id=16161> [7 May 2015].

of health services.

A series of significant changes has been brought about by the Health Transformation Program. These changes resemble the ones that were mentioned in the previous proposals. However, as frequently argued, they could not find necessary grounds to be fully implemented.

With the rise of the JDP to power, along with high popular support, changes like general health insurance and family medicine could be achieved. The General Health Insurance system is an important step towards abolishing the inequalitarian corporatist model of the Turkish healthcare system. The prevailing inequalities among different social insurance schemes were eliminated. Those who pay their premiums have the chance to consult any hospital regardless of their employment status. However, the newly brought system is still far from removing existing inequalities.

The establishment of a premium-based model created new inequalities between those who can pay their premium and those who cannot. The state undertook the responsibility of recompensing for those who had no means to pay premiums, by carrying out means-testing mechanisms. Those who argue in favor of the program claim that it has brought a more egalitarian structure by uniting all social insurance schemes under one institution. On the other hand, some scholars claim that the new system brought an income-based model, replacing the employment status based approach.⁶⁷

Family medicine was given substantial importance to prevent redundant expenses and crowding in the hospitals.

The Development of Medical Tourism and Its Relation to the Health Transformation

⁶⁷ Volkan Yılmaz, "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income" *New Perspectives on Turkey* 48, (Spring 2013): 68.

The Development of Medical Tourism and its Relation to Health Transformation Program

Medical tourism is driven by the for-profit private sector in most countries.⁶⁸ Its rise is situated upon the growth of trade in healthcare services, mobility of patients, and health personnel, progress in information technologies and expanding private health sector. At present, in most of the countries that are engaged in delivering medical tourism facilities, the private sector holds the major share in the provision of services. Planning and regulation, on the other hand, are mostly performed by state institutions.

The development of medical tourism in Turkey has occurred in a way that resembles the progress of the medical tourism sector of many developing countries. Also, economic restructuring led by liberalization has created a space for investment in many developing countries: to expand its health services to attract foreign patients and compete among themselves for the market.⁶⁹

The transformations initiated in 2003 in the healthcare system paved the way for the establishment and development of medical tourism. Regulatory and monitory roles of state institutions expanded health services to attract foreign direct investment and foreign patients. Also, a system in which competition is highly distinctive among hospitals enabled the ways in which medical tourism could extend. These determinants, as emphasized, were introduced by the reforms of the Transformation

⁶⁸ Nicola S. Pocock, Kai Hong Phua, "Medical tourism and Policy Implications for Health Systems: A Conceptual Framework From a Comparative Study of Thailand, Singapore and Malaysia" *Globalization and Health* 7, no. 12 (2011): 6.

⁶⁹ Hadi, 6.

Program.

Sustainability, the continuous improvement of quality, the participation of all components of the sector, the separation of powers (in reference to finance, regulation, provision and monitoring), decentralization, and competition were among the main principles of the Health Transformation Program.⁷⁰ New legislative changes were shaped around these basic principles. Items such as competition and the separation of powers point to the marketization tendencies of the Program. Based upon such priorities, the new system has brought radical alterations that endorsed the growth of medical tourism market in Turkey.

Although all aspects of the program have relative impacts on the development, some issues are in direct relation with the establishment and expansion of the industry. The restructuring of the Ministry of Health and new tools such as efficiency, competition and performance-based payment system ensured necessary organizational and financial set-up for medical tourism.

The Ministry of Health as envisioned by the Transformation Program, is responsible for policy development, standardization, and monitoring. Within the framework of such duties, it has been redesigned as a regulatory institution of strategic importance. In the program, it is emphasized that the Ministry would fulfill the duty of “centralized policy planning” of the health sector.⁷¹ In order to enforce its duty, the vertical structuring of the Ministry was to be replaced by a system that highlights the integrated health service provision. Issues such as human resources, personnel and material management and resource allocation are partly transferred to provincial

⁷⁰ Sağlıkta Dönüşüm Programı, 26.

⁷¹ Sağlıkta Dönüşüm Programı, 26.

organizations (*taşra teşkilatı*) and autonomous hospitals.

Moreover, the Ministry of Health proclaimed responsibility for the development and monitoring of health management education programs. It is this regulatory character of the Ministry of Health that determines and governs the expansion of medical tourism in Turkey. As coordination and planning play crucial roles in the promotion of the industry, The Ministry of Health is a crucial actor in managing and supervising the sector.

Other shareholders of the industry act in line with the policies put forward by the Ministry of Health. However, it is important to note that the delivery of healthcare services in medical tourism is basically provided by the private sector.

The restructuring of the Ministry of Health helped the growth of medical tourism in a way that has ensured the regulation and supervision aspects that are of great importance for the functioning of the sector. Without the Ministry undertaking such a responsibility, expansion objectives for medical tourism would not be in considerable numbers.

Moreover, competition and performance-based payment system force public hospitals to act as private players. Competition is regarded as a mechanism that brings efficiency. All hospitals are held responsible for their efficiency and service quality. Such competitive mechanisms extend the scope of marketization in which medical tourism could position itself.

Second, the share of the private sector in healthcare provision has increased with the Transformation Program. Hospitals that had contracts with the Social Security Institution started to provide service to patients, indicating that the Social Security Institution purchased service from these hospitals. The split between purchaser and provider commences here, as contractual relations form the basis of marketization. As

widely related to the restructuring of the Ministry of Health (split of provision and finance), principles such as efficiency, competition and performance-based payment system contributed the expansion of the industry.

Relying upon the factors mentioned above, medical tourism has developed in line with the changes introduced by the Health Transformation Program. As coordination among different shareholders (state institutions, commercial bodies and health NGOs) of the industry constitutes the basic factor that sustains the development, restructuring of the Ministry of Health gains significance. Its regulatory and monitoring roles enabled the establishment of the industry.

In this chapter, the character of Turkish healthcare system was discussed with regard to the welfare regime debates. Although there exists no linear relationship between healthcare systems and related welfare regimes, it is possible to argue that the organization and finance of health systems provide important insights about the welfare understandings of countries.

The Turkish welfare regime displays similarities with Southern European regimes with regard to high levels of informal activity and family as an important safety net in the absence of state. The healthcare system, on the other hand, has developed from an inegalitarian corporatist structure to a more inclusive setting. However, the fact that the system is basically financed through premiums paid by employees and employers precludes it from attaining a universalistic character, which is based on citizenship.

The 1960s marked a crucial period for Turkish health system as some important attempts were introduced with the intent of abolishing prevailing regional health service inequalities. The 1980s, on the other hand, signified a period in which

market mechanisms came to be involved in healthcare provision. These developments should, of course, be addressed in their relation to the wide-scale structural economic transformations of the day.

The establishment and development of the medical tourism industry in Turkey should be assessed from within a historical perspective. The expansion of the industry has been enabled with changes brought about by the Health Transformation Program, however the necessary ideological and financial restructuring has commenced in the 1980s. This chapter also gave insights about the historical progress of the Turkish health system in its relation to medical tourism sector.

In the next chapter, the role of states will be elaborated in reference to debates of the retreat of the state. In this sense, the degree to which states are considered authority in terms of creating and regulating the markets will be addressed.

CHAPTER 4

THE ROLE OF STATES IN THE MEDICAL TOURISM INDUSTRY

Chapter Four examines the roles of states in the emergence and expansion of the medical tourism industry. As the medical tourism industry has expanded over the last decade, the degree to which states have been influential in the creation of the market has received significant scholarly attention. Due to the profit-oriented character of medical tourism, a large portion of the industry is sustained by private sector hospitals. The market, and its regulations, in which private sector hospitals act have been created and further maintained by state institutions. It is therefore crucial to comprehend to what extent states have been effective on the functioning of the markets.

Privatization and liberalization have been important state policies since the early 1980s. Although states succeeded at perpetuating active roles in terms of intervening in the economy, a general understanding that the state has retreated from the economic sphere has dominated much of the academic and public discussion. Strange suggests that the “retreat” of the state is a process in which state authority and power is diffused and later transferred to private agents, which in the end proceeds with the loss of legitimacy and effectiveness of state action.⁷²

The emphasis is mainly focuses on the decline or loss of state authority and sovereignty. The economic role of nation-states have been regarded as inefficacious and mostly marginalized.⁷³ The decentralization of political authority and the rise in

⁷² Susan Strange, *The Retreat of the State: Diffusion of Power in the World Economy* (Cambridge University Press, 1996).

international constraints have paved the way for inter-dependent policy-making mechanisms and more powerful market forces. Such developments have been interpreted as a legitimacy crisis of the state over the economy and its inefficiency to assert itself as an authority.

Decline, or the retreat of the state, has revived along with economic opening with respect to trade and investment and the expansion of the market forces within the domestic economy. The rise of private actors within the domains of economic activity and the blurring of economic and political spheres have come to constitute the main arguments for those who defend the idea of withdrawal of the state. The inquiry of the intertwining of political and economic spheres arises with the questioning of legitimacy, responsibility and hence, authority of the state.

State institutions, over the course of last two decades, have been perceived as inferior to private actors in terms of administrative and implementation capabilities. However, Hibou discusses that the loss of the state's authority, capacity, and legitimacy is based on a normative analysis which stems from the developmentalist ideology of the 1950s.⁷⁴ She further argues that the state has transformed into an entity that employs different forms of authority over all aspects of the economy.

Hibou also asserts that privatization should not be regarded as the emergence of new actors in competition with the state. Market forces, since the early 1980s, have been the legitimate institutions that exercise power over the regulation and enforcement of the economy. Privatization, which intensified the legitimacy of private actors, affects

⁷³ For a full discussion on the economic role of nation-states, see. Robert B. Reich, *The Work of Nations: Preparing Ourselves for 21st Century Capitalism* (New York: Simon and Schuster, 1991); and Peter Drucker, *Post Capitalist Society* (Oxford: Butterworth- Heinemann, 1993).

⁷⁴ Beatrice Hibou, "From Privatising the Economy to Privatising the State: An Analysis of the Continual Formation of the State," in *Privatising the State*, ed. B. Hibou (New York: Columbia University Press, 2004): 2.

the ways in which there emerged new ways of governing for state institutions. The state is adapting not only to external constraints, but to internal ones also, without a loss of control.⁷⁵

Although much criticized for the inefficiency of regulating capitalism, states have challenged this perspective by intervening in the economy through various, yet transformed means. Changes in relations between the public and private, economic and political did not minimize the role of the states in the economy, but rather generated new forms of state intervention. Thus, it is possible to argue that the state is not endangered by the rise of the private sphere and globalization⁷⁶ ?

The ground upon which medical tourism has expanded indicates that the state is as influential as ever, albeit assuming different responsibilities. The authority and legitimacy of state institutions are sustained through regulation and monitoring aspects. Privatization, in its own right, does not imply autonomy from the state. The process itself is closely connected to the state authority both in regulative and financial milieu. As medical tourism industry has received significant support from government agencies in the last decade, states have become an active part of promotion and marketing activities alongside with the private sector shareholders. Given the revenue generating character of medical tourism and expected rise in healthcare costs, both developing and developed countries regard the industry as an alternative. However, it should be emphasized that the driving forces remain distinctive for developing countries when compared to the developed world.

Developing countries' governments have actively promoted medical tourism

⁷⁵ Ibid., 4.

⁷⁶ Ibid., 7.

activities as part of their economic development and tourism policies. Accordingly, a series of legislative acts have been put forward in the domains of regulation, finance and provision of medical tourism services. Thus, medical tourism is placed at the heart of development policies in some countries and enhanced the intensification of public and private relationship.

First World countries, on the other hand, opt for international medical activity to exploit the cost advantages of medical tourism. In this respect, developing distinct analysis for the two groups would provide a better understanding with regard to efforts to establish medical tourism as a national strategy.

Although medical tourism has certain characteristics that are common in all developing countries, the emergence of the market corresponds to different time frames. Accordingly, the degree to which state holds liability over some aspects differs. In this manner, medical tourism markets of Singapore and Dubai, alongside with India, Thailand, and Malaysia are considered as the “first wave” of Asian medical tourism.⁷⁷ It is also emphasized that the post-2008 expansion of Japanese and South Korean medical tourism markets which represent the “second wave”, are signified by increasing state involvement.⁷⁸ Japanese and Korean governments have targeted to utilize medical tourism as part of their future economic growth.⁷⁹ Thus, it is critical to assert that some developed countries such as Japan and South Korea seek to expand their medical tourism capabilities for the same reasons as for the developing world. Hence, economic growth appears as one of the main drivers behind

⁷⁷ Mika Toyota, "Medical Tourism Asia 2.0: Japan, South Korea and Taiwan" (Paper, Workshop of Patients on the Move: Medical Tourism in Asia and the UK, Singapore, March 23, 2011).

⁷⁸ Ibid., 6.

⁷⁹ *The New York Times*, 13 November 2008.

governments' efforts oriented toward the industry.

The main exporting countries of medical tourism are primarily concerned with the economic facet of international medical mobility. Increasing economic growth by virtue of tourism revenues and foreign direct investment could be regarded as the main drivers behind the efforts of developing countries to establish and institutionalize medical tourism as an export item.

As compared to regular tourist incomes, revenues generated from medical tourism are considerably high due to patient necessity of traveling with a company. Considering the complex treatment procedures of the diseased, other expenses such as transportation, accommodation, and post-operative care tend to be more expensive than the cost of a regular tourist who spares leisure time. For example, it has been estimated that medical tourists visiting Asia spend over twice as much as traditional tourists.⁸⁰

Also, health professionals decide to stay as there arises better-paying job opportunities in their home countries with the growth of the medical tourism sector. Such occupational changes may turn in favor of the governments both in regulating the public health system and overall satisfaction with the healthcare services.

In order to become internationally renowned medical hubs, governments develop national strategies to attract medical tourists and foreign direct investment to their expanding health sector. Their strong roles in the regulation, finance, promotion, and marketing show them as ardent supporters of the industry. Although their strategies may resemble each other, the degree to which they could be actualized remain politically bounded.

⁸⁰ *Toronto Star*, 12 July 2007.

Developing niche treatment markets, introducing medical tourist visas and establishment of committees and departments within the state bodies for promotion could be considered as the main initiatives that governments carry out for the purpose of expanding the industry. Along with such organizational elements, there also exists financial support from governments, such as lower import duties and tax concessions.

Southeast Asian governments, in this respect, could be regarded as primary supporters of the medical tourism industry in their countries. The establishment of medical tourism sector in these countries can be traced back to the late 1990s financial crisis. As the savings of the emerging Asian middle class was destroyed with the crisis and it became no longer possible to pay for private healthcare, private hospitals revised their marketing strategies to target overseas patients.⁸¹

Along with the rapid growth of the private sector in the following years, in countries such as Thailand, Malaysia and Singapore, medical tourism emerged as an important business opportunity. These governments have struggled to introduce financial and administrative measures to enable the growth of medical tourism. To this end, the expansion of the industry was set as a development goal.

In 2003, Thailand's Board of Investment introduced its medical hub policy, where the Ministry of Commerce, Department of Export Promotion, and the Ministry of Health along with private hospitals became the main implementers.

In 2004, Singapore Medicine was established as a multi-agency government initiative with the purpose of advancing the sector. The growth of medical tourism in Singapore is closely connected to the economic growth and Singapore's government

⁸¹ Leigh Turner, "Medical Tourism: Family Medicine and International Health-related Travel" *Canadian Family Physician* 53, no. 10 (2007): 1646.

agencies have integrated policy stances that strongly support the expansion. The Ministry of Health explicitly puts forward the goal to utilize the country's economic value to become a regional medical hub.

Although Malaysia's national health plan does not cover medical tourism as a strategic aim, in 2003, the Ministry of Health formed an inter-ministerial committee for the promotion of medical tourism. At this point, trade and tourism ministries assumed primary roles vis-a-vis organizing and promoting the sector facilities to increase economic growth and facilitate international trade in the services sector.

Furthermore, the availability of the medical tourist visa emerged as an important strategy to develop medical tourism. For example, India introduced an M visa category in 2005 to reach out to the growing number of international patients.⁸²

The development of medical tourism was aimed to be expanded by some other measures such as forming niche markets. Specializing in particular types of treatments is regarded as a way to increase the number of medical tourists.

Thailand, in this respect, created a niche market for cosmetic surgery and sex change operations. A U.S. medical tourism company called Cosmetic Surgery Travel organizes plastic surgery vacations to Thailand.⁸³ Singapore, on the other hand, specializes in advanced treatments such as cardiovascular diseases, stem cell therapy and neurological operations.

In terms of financial strategies, many developing countries inducted government funds to cultivate medical tourism potentials. India's medical tourism is

⁸² Rupa Chinai, Rahul Goswami, "Medical Visas Mark Growth of Indian Medical Tourism," *Bulletin of World Health Organization* 85, no. 3 (March 2007): 164.

⁸³ "List: Medical Tourism Operators," <http://www.travel-lists.co.uk/travel/listings/categories/miscellaneous/medical-tourism> [17 May 2015].

believed to have rapidly grown with the aid of government. The provision of public land and reduced tariffs on imported medical equipment in private hospitals serving medical tourists are among major Indian government subsidies.⁸⁴ These incentives are given in line with the government's National Health Policy of 2002, which considered medical tourism as an acknowledged export.

Other prominent medical tourism destinations such as Thailand, Indonesia, and Nepal have also lowered restrictions on foreign direct investment with the purpose of promoting the growth of the industry. Also in India, Malaysia and Thailand, tax concessions are given to medical tourism providers and tourism office campaigns, along with land purchase and infrastructure subsidies.⁸⁵ In addition to financial support, countries such as Malta, UAE and Cyprus promote medical tourism through trade fairs, and airlines discounts.

First World countries, on the other hand, have endorsed the expansion of the global medical tourism industry primarily to exploit the cost advantages of medical treatment potentials in developing countries. Although these countries hold established and well-organized health systems which also served Third World patients before international medical mobility has acquired a new dimension, the contraction of health budgets incline governments to consider alternative medical remedies.

As has been emphasized several times, the underlying character of the emerging medical tourism phenomenon is the reverse flow from developed countries to the developing world. Thus, strategies advanced by the developed nations lie within

⁸⁴ Ganapati Mudur, "India Plans to Expand Private Sector in Healthcare Review," *BMJ* 326, (March 2003): 520.

⁸⁵ Mohd Jamal Alsharif, Ronald Labonte, Zuxun Lu, "Patients Beyond Borders: A Study of Medical Tourists in Four Countries," *Global Social Policy* 10, no. 3 (December 2010): 318.

the demand to benefit from the cost advantages of emerging medical tourism markets.

As welfare systems in developed countries witnessed a considerable downsizing with the structural economic and demographic changes, partially commodified private healthcare has gained importance. Although problems faced by developed countries vis-a-vis health coverage remain diversified, the main factor that drives those countries to benefit from medical tourism is the lower costs of medical treatments in developing countries.

The U.S., which has a private insurance system, supports medical tourism in the form of medical outsourcing. As there exists a high number of people without health insurance coverage (44.8 million in 2013)⁸⁶ in the U.S., medical tourism has become an important alternative for those who cannot afford medical treatments at home.

Some economists in the U.S. assert that importing foreign health workers and exporting patients to developing countries is the simplest and cost-effective solution to its healthcare problems.⁸⁷ In order to develop medical outsourcing, a US-based insurance group enabled Blue Cross and Blue Shield members in 2009 to utilize the services of a hospital in Mexico.

It is also reported that some insurance companies in the U.S. send their clients to JCI-accredited hospitals in Thailand, Singapore, Turkey, Ireland and Costa Rica.

Countries with national health systems have also faced significant challenges in terms of providing healthcare to its citizens. In Britain, nearly 900,000 people are

⁸⁶ "Early Release of Selected Estimates Based on Data from the 2013 National Health International Survey," <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201406.pdf> [7 August 2015]

⁸⁷ *Financial Times*, 23 December 2008.

waiting for admission to National Health Service hospitals where capacity shortages cause more than 50,000 operations each year.⁸⁸ Canadians, on the other hand, wait 121 days or more on average for necessary medical treatment and the wait time is increasing.⁸⁹ Accordingly, the rate of cross-border patient flows has risen in the last years.

Given the reasons stated above, medical tourism constitutes an important part of policy agendas of First World countries. Increasing health expenses stemming from increasing life expectancies and ageing populations necessitate governments to find alternative ways to overcome rising health spendings.

In this chapter, the role of the states in maintaining medical tourism industry was elaborated on the basis of theoretical discussions. State institutions continue to uphold authority over several aspects of the economy, particularly in regulation.

In the next chapter, medical tourism in Turkey will be addressed in detail. The elements of governance, finance, and provision of medical tourism activities will be touched upon with regard to systemic level changes and statistical data. In the governance part, the regulatory and monitory role of the Ministry of Health will be elaborated along with the GATS commitments to which Turkey is liable. The finance part will demonstrate the degree to which the state invests in the medical tourism sector both through incentive mechanisms and the financing of foreign patients. Last, the provision of medical tourism will indicate the share public and private hospitals

⁸⁸ "Why is Medical Tourism a Solution for the United States, Canada, and the United Kingdom?" http://bestmedtrip.com/index.php?option=com_content&view=article&id=67&catid=54 [18 May 2015].

⁸⁹ Nadeem Esmail, Maureen Hazel, Michael A. Walker, "Waiting Your Turn. Hospital Waiting Lists in Canada 2008 Report," *Fraser Institute Studies in Healthcare Policy* (October 2008): 4.

delivering medical services to international patients.



CHAPTER 5

MEDICAL TOURISM IN TURKEY

This chapter develops a comprehensive framework of medical tourism in Turkey. The main aspects of medical tourism will be elaborated through a conceptual framework that facilitates analytical understanding. The important actors that have been prevalent in the expansion of the industry will also be highlighted to reiterate that state institutions are actively engaged in the process.

Governance, financing, and provision issues will be discussed in their relation to broader governmental policies about the liberalization of healthcare services. In this regard, the governance part will comprise the regulation and monitoring of medical tourism policies as well as the GATS commitments to which Turkey is subject. The role of the Ministry of Health and other shareholders will be analyzed with regard to the organization of the medical tourism industry.

The financing part is formed upon two basic subjects; the degree to which state institutions assume responsibility for the investments in health tourism sector and the financing of medical activities of foreign patients. Last, the provision of medical tourism will be addressed in order to comprehend the degree to which public and private hospitals provide healthcare services to medical tourists.

The provision of healthcare services constitutes an important portion of development debates since health professionals may opt for better-paying private hospitals, which in turn leads to a deficiency of health personnel in public hospitals. However, due to the lack of extensive analysis, the issues of brain drain and recovery for local patients remain uninvestigated. As these subjects are crucially important to understand as to whether medical tourism can promote development, there is much

need for in-depth research.

Although medical tourism has witnessed significant growth in recent years, nevertheless, there remains considerable inadequacy in the medical tourism literature in Turkey. The existing scholarly work mainly focuses on the analysis of the sector from a management perspective. This is due to the recent and emerging character of the medical tourism industry.

There also exists large and distended information on media, yet only a limited amount of it could be considered authoritative. Accordingly, this chapter is basically established upon government and consultancy firms' reports.

In Turkey, policy-making mechanisms develop strategies under the name of health tourism, which consists of three subgroups, as discussed above. However, it is important to note that there has been a special effort to advance medical tourism as this sector promises greater growth rates as compared to thermal/spa/wellness tourism and elderly/disabled tourism.

In Turkey, it is possible to cite numerous actors that have been effective in the growth of medical tourism as an alternative. These actors range from the Ministry of Economy to tourism agencies that assist international patients in their medical travels to Turkey. However, it is crucial to underline that the creation of the medical tourism market and its functioning rely heavily on the efforts of state institutions as private mechanisms are constantly supported in financial and promotional terms. In this sense, it is possible to categorize the main actors in three groups: public actors that are mainly state institutions active both in regulation and financing, private actors that are prominent basically in provision of health services, and health NGOs (non-governmental organizations) that work with regulatory bodies in regulation by providing analysis of the market.

The medical tourism industry in Turkey has developed in parallel with two external factors; the growth of tourism and the transformation of healthcare system have important effects on the expansion of the market. As will be discussed in the following parts of the chapter, patients who come to Turkey for touristic purposes and consult emergency or any other health services during their stay are counted as part of international patients. They are classified under the group of “health of the tourist” and are considered health tourists. As the number of tourists increase, the incidence of emergency consultation rises accordingly.

The Health Transformation Program, on the other hand, enabled the ways in which medical tourism could emerge as an alternative tourism model as the involvement of the private sector rose. The partial autonomization of hospitals in financial and regulative terms facilitated the growing involvement of private forces in the healthcare system.

New legislation designates private hospitals as equal to public hospitals in terms of health service provision. Patients are allowed to get services from private hospitals by paying additional money. The General Health Insurance system rendered access to private sector hospitals as Social Security Institution commenced purchasing health service from hospitals on a contractual basis. In this manner, both public and private hospitals became subject to certain market rules such as competition and performance-based system. Since private hospitals cannot solely focus on international patients, the opening up of the domestic market eased their progress in entrance to the medical tourism industry.

Another important transformation was the restructuring of the Ministry of Health to regulatory and monitory duties. As hospitals were given administrative autonomy, the Ministry of Health transferred its role of organizing certain assignments

(*atama*) for employees of high degree. Accordingly, it undertook the role of regulating and monitoring the medical tourism policies. The growth of the medical tourism industry has been possible with the inclusion of the Ministry of Health as the main regulator, a role which was rendered possible with the Health Transformation Program.

Policy makers in Turkey strive to assert medical tourism as an export item. Their efforts rely upon basic economic advantages. Investing in medical tourism industry enables increase in gross domestic product, generate foreign exchange, create a more favorable balance of trade and foster tourism.⁹⁰

It is put forward as an area to increase employment, promote income growth, boost tourism diversity and attract investment in the 10th National Development Plan. It is estimated that the current market size of the Turkish medical tourism market is US \$2.5 billion. It is projected to be \$8 billion in 2017 and targeted to reach \$20 billion in 2023.⁹¹

According to official figures, the number of international patients was 156,176 and it was raised to 262,000 in 2012.⁹² This signifies an increase of 68 percent in foreign patients.⁹³ It is expected to rise in high numbers in 2019, reaching one million. The government strives to raise the number to two millions of international patients in 2023. In Table 2, it is seen that there was a significant rise in the number of international patients over the course of five years.

⁹⁰ Arellano, 195.

⁹¹ "Healthcare Industry in Turkey", Republic of Turkey Prime Ministry Investment Support and Promotion Agency (ISPAT) in conjunction with Deloitte, (January 2014): 86.

⁹³ "Türkiye Medikal Turizm Değerlendirme Raporu 2013" (Ankara: T.C. Sağlık Bakanlığı, 2013): 15.

Table 2. Number of International Patients by year

	Public Health Institutions	Private Health Institutions	Total
2008	17, 817	56, 276	77, 093
2009	21, 442	70, 519	91, 961
2010	32, 675	77, 003	109, 678
2011	41, 847	114, 329	156, 176
2012	43, 904	218, 095	261, 999

Source: Ministry of Health, Evaluation Report on Medical Tourism in Turkey

http://www.saglikturizmi.org.tr/yonetim/templates/addons/ckfinder/userfiles/TMTD_2013_raporu.pdf

The development of medical tourism in Turkey is closely related to global economic and political forces. The changing nature of welfare service provision and the liberalization of healthcare services have affected the ways in which medical tourism is regarded as a growth promising industry.

Decreasing production rates, rising healthcare expenses, and disparities between social security systems seem to escalate the pressure on states about social service provision in developed countries.⁹⁴ The rise in healthcare spending originate from the increase in elderly population, improvement of income levels, advances in new health technologies and increase in health service demands.⁹⁵ Given the economic and demographic factors in the developed world, developing countries regard medical tourism as an area that promotes economic growth.

The main importing countries (or source countries, those who receive treatment) prefer Turkey for it promises low-cost treatment with high quality. Patients coming from developed countries (mostly North America and Western Europe) prefer Turkey for its shorter waiting lists and high-cost medical operations. Western

⁹⁴ “Onuncu Kalkınma Planı (2014-2018)” (Ankara: T.C. Kalkınma Bakanlığı, 2013): 10.

⁹⁵ Ibid., 10.

European countries fall short of providing health services in short time periods, whereas in the U.S. a large portion of the population remains uncovered by any social security system.

Other groups of medical tourists choose Turkey for it provides certain operations that do not exist in their countries. Fertility treatments fall into this group and attract a significant numbers of tourists from wealthy Middle Eastern countries. Relatively lower-income group of health tourists opt for receiving medical treatment in Turkey since there exists no necessary medical equipment in their home country.

Turkey has bilateral health agreements with certain countries regarding the treatments of patients coming from countries such as Kosovo, Azerbaijan and Libya. Another important component of Turkish medical tourism is the diasporic patients coming from European countries via social security agreements signed between Turkey and other European States.

Certain medical operations in Turkey are substantially cost-effective when compared to Europe and North America. It is possible to save up to save 60 percent in operations such as heart bypass and spinal fusion. The fact that Turkey has lower medical costs than most European countries has been as a crucial factor for the expansion of medical tourism.

The regulation and monitoring (governance) of the Turkish medical tourism sector is assumed by state institutions. Other shareholders of the industry are called to participate in the policy-making processes, albeit undertaking limited duties. The state also takes on certain aspects of medical tourism financing, both on the investment and service level. The expenses of some international patients (those who come to Turkey via bilateral health agreements) are covered by the Turkish government. These patients mostly get treatment in public hospitals in certain cities. The provision of medical

tourism services is mainly carried out at private hospitals. Medical tourists who travel to Turkey paying out-of-pocket prefer private sector hospitals. In the following parts of the chapter, governance, finance and provision of medical tourism in Turkey are further analyzed.

The Governance of Medical Tourism in Turkey

Governance mainly signifies the regulation and monitory aspects of the medical tourism industry. The Ministry of Health is the main mechanism of regulation and monitoring in Turkey. Along with the Ministry of Health, the Ministry of Culture and Tourism, and the Ministry of Economy play important roles in facilitating the expansion of the industry. In this respect, government reports will be analyzed in order to comprehend the ways in which state is involved in the development of medical tourism.

GATS is a major player in shaping the services trade. As GATS constitute the legislative and legal framework of regulation of trade in services, the commitments that Turkey has made gain prominence in understanding the general scope of regulation at systemic level.

Governments assume certain responsibilities in developing medical tourism in their countries. Some governments tend to undertake a supportive role whereby private sector holds the main say over governance and provision. However, in some countries, governments lead the industry with regulatory and monitoring legislations. Turkey falls under the second group of this classification wherein the governance of medical tourism is driven by state agencies.

There have been an immense effort to institutionalize medical tourism in the

recent past. The Unit of Health Tourism was established with the decree law no. 210 in 2010 within the body of General Directorate of Basic Health Services. The unit was formed of four different offices; medical tourism, thermal/spa/wellness tourism, elderly/disabled tourism and international coordination.

In 2011, it was transferred to the General Directorate of Treatment Services and maintained its duties as the Coordinatorship of Health Tourism. Finally, within the scope of restructuring of the Ministry of Health, the Department of Health Tourism was founded within the body of the General Directorate of Health Services.⁹⁶ It carries out its duties in four main sections, medical tourism, thermal/spa/wellness tourism, elderly/disabled tourism and health of the tourist.

After establishing an institutionalized framework in 2010, policy makers considered public involvement obligatory basically for three purposes, policy-making, monitoring, and the promotion of medical tourism. In the activity report published in 2010, it is underlined that the Ministry of Health should bring fast-growing health tourism industry under control, sustain standards and norms, envisage planning and structuring for the functioning of health tourism, and act as a consultation mechanism.⁹⁷ Thus, they set their mission as ‘creating added-value for the country by regulating and monitoring the field through forming and implementing policies about medical tourism.’⁹⁸

The branch office of medical tourism, along with the branch offices of thermal/spa/wellness tourism and elderly/disabled tourism, was established within the

⁹⁶ Republic of Turkey, *T.C. Resmi Gazete*, no. 663, 2 November 2011.

⁹⁷ “2010 Yılı Faaliyet Raporu” (Ankara: T.C. Sağlık Bakanlığı, 2010): 21.

⁹⁸ *Ibid.*, 21.

body of the Unit of Health Tourism in 2010. Its duties were specified as the planning of the institutions that operate in this field and their provision with the necessary permissions, assessing these institution with regard to their health services, keeping records of the existing medical tourism centers, organizing training programs for health personnel and issuing certificates, coordinating government agencies and taking part in policy-making processes.⁹⁹

In regard to policy-making, it is possible to say that the importance of such a duty was emphasized in almost all reports. Policy and legislation making, centralized implementation, sustaining quality and accreditation criteria, bringing standards and norms, coordination among all related institutions were indicated as part of the policy-making process.

At first, coordination among NGOs and the private sector was put forward. However, as the industry expanded in large numbers, coordination among the Ministry of Economy, the Ministry of Culture and Tourism and international airlines was necessitated and indicated as goals to be achieved.¹⁰⁰ Also, creating the legislative framework that enables price differentials among health tourism establishments was targeted in the 10th Development Plan.

As definitions and categorizations became more explicit in the industry, the Department of Health Tourism classified its targets with different categorizations. In the 2012 Report, the planning of the services for health tourism and “health of the tourist” (for patients who consult emergencies during their stay as tourists) was listed as the major aim of the Department. Authorizing health tourism establishments and

⁹⁹ “Stratejik Plan (2013-2017)” (Ankara: T.C. Sağlık Bakanlığı, 2012): 118.

¹⁰⁰ Ibid. 118.

coordinating the activities of patients who come to Turkey via bilateral health agreements were also designated as their responsibility. Although the institutionalization of health tourism started in 2010, related concepts, categorizations and targets became relatively clear in 2012.

Monitoring constitutes an important part of the duties that the Ministry of Health has undertaken. Ensuring auditability and conducting inspections at national and international standards are stated in every report. Monitoring activities are an important part of Ministry of Health objectives as these tools help build an institutionalized field.

The promotion of health tourism in Turkey is an area that attracted the interest of the Ministry of Health. Attendance of international conferences is regarded as an effective way of promoting the Turkish medical tourism industry. These conferences are mostly about the current state of global health tourism market. Generating networks and making projections about the future of the sector are of great importance for Turkish policy makers. The efforts to promote health tourism have been frequently emphasized in government reports as well. In order to maintain promotion, it was suggested to establish a fund to finance these activities.¹⁰¹

Carrying out international promotion activities and financing them, attendance of international meetings and organizations, coordination between universities, NGOs and public agencies and promotion and marketing activities in target countries were considered as part of the Ministry of Health duties. Although the private sector was never mentioned in promotion activities in previous reports, the 2013 Activity Report puts forward the necessity to cooperate with the private sector to promote and market

¹⁰¹ “2010 Yılı Faaliyet Raporu” (Ankara: T.C. Sağlık Bakanlığı, 2010): 22.

health tourism.

Several government officials attended international health tourism conferences. The 3rd Health Tourism and Global Care Congress in Los Angeles, the 1st Health Tourism Congress in Kuwait, and the 1st Health Tourism Congress of Islamic Countries in Iran are among the organizations that Turkish officials attended to follow the development in the global health tourism industry.

Apart from regulation, monitoring and promotion activities, the Ministry of Health provides the industry with consultation and service mechanisms. It has translated several articles into Turkish and prepared reports about the development of the industry. A call center that operates within the body of Department of Health Tourism was established in 2012. Calls can be made in English, German, Russian and Arabic. There are 21 employees who work on a contractual basis and they have a teleconference service if needed.

In addition to translation and call center services, the Ministry of Health has created an official website for health tourism in Turkey. It operates in four different languages. The potentials of Turkish medical tourism are pointed out on the website. This could be regarded as part of the promotion activities that Ministry of Health has assumed. The Department also organizes meetings and training programs for the delegates of the Ministries, institutions and the private sector.

In addition to the influence of the Ministry of Health in the governance of medical tourism, other governmental bodies have also assumed certain duties in regard to the development of the industry. For example, improving medical tourism and thermal tourism as alternative tourism models has been included as part of the objectives of the tourism strategy of the Ministry of Culture and Tourism. Forming tourism settlements incorporated of different integration areas such as health and

education has also been stressed in the tourism strategy of 2023 of the Ministry.

The Strategic Plan of the Turkish Public Hospitals Institution (2014-2018) also states some goals for improving medical tourism. Cooperating with related public agencies and NGOs, publishing guides for international patients, and signing protocols with certain insurance companies and intermediate establishments are given as significant items to comprehend their involvement. Furthermore, in the Commission Report of the 10th Development Plan (Strategical Plan 2014-18), Turkey is demonstrated as an emerging market and the improvement of competitive capacity of medical tourism is targeted.

It is also crucial to understand the ways in which policy makers conceptualize health tourism at both the national and international level. How they define and address certain issues is reflected in their regulation processes. As mentioned above, health tourism comprise three subgroups, namely medical tourism, thermal/spa/wellness tourism, and elderly/disabled tourism.¹⁰² It is underlined that the provision of medical tourism is carried out by private health establishments.

The impetus behind the growth of medical tourism activities are regarded as demographic changes, increasing costs of healthcare services, decrease in income levels, easier access to information, and intermediary services such as low-cost airlines and tourism agencies.

Particularly in Western countries, the cost of elderly care is rising in parallel to the increasing costs of healthcare. The expansion of the elderly population and chronic diseases put pressure on governments about healthcare spending. Insurance companies, on the other hand, have seen the possibility of cheaper health services and inclined

¹⁰² “Stratejik Plan (2010-2014)” (Ankara: T.C. Sağlık Bakanlığı, 2010): 80.

towards medical facilities in developing countries.

On the side of consumers, the decrease in income levels after the 2008 economic crisis has been effective in bringing them to savings. Recent advancements in technology and low-cost air travels are counted as other factors that affected the growth of medical tourism. The expansion of the industry is related to these factors.

The strengths and weaknesses of the medical tourism in Turkey were also pointed out in the Ministry of Health reports. High standards in private hospitals and low costs of health services are counted as strengths. There are more weaknesses than strengths.

The insufficiency of health personnel (doctors and nurses), qualified translators, intermediate staff, lack of government policy on medical tourism and legislation appear as important factors that disrupt the development. Moreover, the lack of institutionalized structure and coordination among different shareholders and inadequacy in promotion activities are regarded as other weaknesses of the industry.

The Ministry of Health has actively supported the growth of the market. However, health tourism is regarded as a tool that brings risks and opportunities at the same time. As for the opportunities, employment (health personnel and intermediate staff), foreign exchange inflow, new investment opportunities (resorts, thermal centers, hospitals), political power and empowerment of financial position of the private sector were addressed. Nevertheless, there also exists some risks that health tourism might bring. Health professionals might opt for better paying job opportunities at private hospitals, the rise in demand increases prices for local patients, infectious diseases (from medical tourists) may diffuse in the exporting country and private hospitals may prefer serving only to international patients. However, it is improbable that private hospitals serve only medical tourists as the industry has not been yet developed to meet

the costs.

Although the Ministry of Health holds the major say over the regulation and monitoring activities of medical tourism, there also exists other shareholders that are of great importance for the development of the industry. Health NGOs, travel agencies, intermediate and consultation firms, airlines companies, technology and construction sectors are among the components of medical tourism services.¹⁰³ The standardization and accreditation of these institutions is also undertaken by the Department of Health Tourism.¹⁰⁴

These newly emerging industries have influenced the ways in which international patients obtain easier movement, which in turn expanded the industry. Some medical equipment and pharmaceuticals corporations make more profits than large hospitals.¹⁰⁵ It is therefore crucial to address medical tourism from a multi-dimensional perspective, including health, trade and tourism policies.

With regard to policy-making issues, the Ministry of Health intends to include major shareholders in the process for consultation purposes. The assessment meeting that was held in 2010 by the Ministry of Health portrays the conceptual framework of the medical tourism industry in Turkey. The demands and requests of health NGOs during this meeting helped shape Ministry of Health's regulative activities. In the meeting, four major issues were discussed, the need for state institutions to regulate the industry, identifying medical tourism within the scope of foreign trade, investments in the sector and coordination among different shareholders. There were delegates from

¹⁰³ "Türkiye Medikal Turizm Değerlendirme Raporu 2013" (Ankara: T.C. Sağlık Bakanlığı, 2013).

¹⁰⁴ "Sağlık Turizminde Süreçler ve Aracı Kuruluşlar Araştırma Raporu" (Ankara: T.C. Sağlık Bakanlığı, 2012): 7.

¹⁰⁵ "Stratejik Plan (2010-2014)" (Ankara: T.C. Sağlık Bakanlığı, 2010).

private sector hospitals, state agencies, and airlines companies. The private sector delegates highlighted that the state should not regard private sector as a threat and adversary, but rather it should strive for eliminating the legislative obstacles that disrupt the growth. They insisted that the government should intervene in the industry only with the regulatory and monitory role. They also emphasized that the Ministry of Health cannot be a provider and should limit its role to certain responsibilities.

A delegate from the Foreign Economic Relations Board (*Dış Ekonomik İlişkiler Kurulu*) argued that the promotion of health tourism should be left to the Association of Turkish Travel Agencies (*Türkiye Seyahat Acentaları Birliği*). Also, the Turkish Airlines delegate claimed that they take part in the sector as a supporter and offer discounts in medical tourism, but not in spa/wellness tourism. The officials from the Ministry of Health emphasized that they are in the industry as a coordinator, regulator, and inspector.

They also drew attention to the inefficient numbers of health personnel and the need to import doctors from abroad. For a well-functioning public health system, the ratio of doctors should not be less than 70 percent of all doctors working in that country. Along with these, it was suggested that medical tourism should be considered as an export item and it could improve the image of the country. Finally, the issue of obtaining a visa was put forward as another major problem.

Given the brief content of the meeting, it could be understood that private sector bodies consider state as the regulator and coordinator of the industry. The involvement of state hospitals as provider does not seem possible for private sector delegates. The promotion of medical tourism was tried to be assumed by the Association of Turkish Travel Agencies; however, state agencies offered cooperation instead of withdrawing from the scene.

Most of the suggestions about re-conceptualizing medical tourism as an export item and importing foreign doctors from abroad were accepted. The necessary legislations were initiated and further measures about development were mentioned in the subsequent reports. It is possible to argue that medical tourism is regulated and monitored by state institutions, but to what extent it is independent in taking measures is an issue of another debate.

Apart from the governmental bodies that are active in the policy making of medical tourism, there also exists other actors involved within the process institutionalization of the industry. The Private Hospitals and Health Institutions Association, the Accredited Hospitals Association, Health Industry Employers' Association of Turkey (*Türkiye Sağlık Endüstrisi İşverenleri Sendikası*) and the Health Establishments Association (*Türkiye Sağlık İşletmeleri Derneği*) are among the actors that closely cooperate with the relevant ministries in policy making issues and protect the rights and interests of various health sector components.

The Ministry of Health, the Ministry of Economy, the Ministry of Culture and Tourism and health NGOs emerge as the major actors of governance aspect of medical tourism. However, it is crucial to understand other mechanisms that shape the legislative framework of medical tourism activities in Turkey. In this respect, GATS gains prominence due to its legal structure for regulating services trade.

GATS is a treaty of the WTO that came into force in 1995 after the Uruguay Negotiations. The general aim of GATS is to liberalize trade in services sector. All WTO members are at the same time members of GATS, and they have assumed commitments in certain services sectors. Countries are free to choose the sectors to open up for liberalization and the mode of supply that would apply to these particular services. The removal of barriers create a space for free movement of services across

countries.

The agreement exhibits four modes of supply for the delivery of services in international trading. These modes are cross-border supply, consumption abroad, commercial presence, and the presence of a natural person operate. In the case of medical tourism, modes two, three and four are frequently in effect for they meet demand and supply aspects. Under mode two, patients travel abroad to obtain medical treatment in a foreign country. Mode three, on the other hand, apply to foreign investment in a country's health sector whereas mode four designates the presence of medical personnel in these hospitals.

As indicated, medical tourism is a form of consumption of a service in a foreign country. The annex on mode four claims that members are free to take measures regarding citizenship, residence or access to the employment in the market on a permanent basis.

While services form over 60 percent of global production and employment, they present around 20 percent of total trade (balance of payment basis). Country commitments and the degree to which they enable liberalization in their services sectors vary significantly. Over 90 percent of WTO members assumed certain commitments on tourism services whereas 70 percent of them were involved with commitments in sectors like finance or telecommunication. However, education and health services constitute nearly less than 40 percent of the commitments.¹⁰⁶ This signals a tendency to conceptualize health and education as services to be commercialized and privatized.

Turkey submitted commitments to the WTO in 1994, 1997, and 1998. The

¹⁰⁶ Rupa Chanda, "Social Services and GATS: Key Issues and Concerns", *World Development* 31, no. 12 (December 2013): 2004.

coverage of commitments that Turkey has contracted generate almost 47 percent of all commitments, which corresponds to 18 percent more than other developing countries. It has made commitments in nine major services sector and related 84 sub-sectors. Along with sector specific commitments, there also exists horizontal commitments that apply to all sectors that are included in the schedule of Turkey.

Sectors in which Turkey has made commitments include business, communication, construction and related engineering services, education, environmental services, financial services, health-related and social services, tourism and travel-related services, and transport services. Hospital services are given as a sub-service of health-related and social services.

With regard to mode three on hospital services (commercial presence), it is stated that foreigners may establish private hospitals in Turkey with the permission of the Ministry of Health. Mode one (cross-border supply) is given as “unbound” due to the lack of feasibility whereas mode two (consumption abroad) is indicated as “none” meaning that there is no limitations on market access.

The Finance of Medical Tourism in Turkey

The financing of medical tourism could be elaborated on two levels. The first one comprises of the financing of medical treatments of foreign patients whereas the second level focuses on the finance of sectorial necessities such as promotion, infrastructural capabilities, intermediary services, and investment incentives. The involvement of the state on both levels reveals the fact that state assumes responsibility on providing necessary financial assistance and legitimation upon the expansion of the industry.

Foreign patients that come to Turkey for medical treatments are classified in four groups. These groups are basically formed upon their ways of financing health services. The notion of “international patients” was first categorized in the 2013 Report on Health Tourism Activity. Medical tourists, patients who receive treatment within the scope of “health of the tourist” patients of bilateral health agreements, and those who come via Social Security Institution agreements are all listed as international patients. Medical tourists, who pay out of pocket, constitute the first group of international patients. The number of the tourists who receive health services during their stay in Turkey emerges as the second group of international patients.

Table 3. Number of International Patients by Categorization, 2012

	Medical Tourism	Bilateral Health Agreements	Social Security Agreements	Health of the Tourist	Total
Total	169462	544	21530	70463	261999

Source: Ministry of Health, Evaluation Report on Medical Tourism in Turkey
http://www.saglikturizmi.org.tr/yonetim/templates/addons/ckfinder/userfiles/TMTD_2013_raporu.pdf

The first group of international patients is medical tourists who travel outside their domiciles to receive treatments abroad. The utilization of technology intensive operations is distinctive in medical tourism. These processes involve mostly second and third levels of health services, including but not limited to, medical check-ups, heart surgeries, organ transplantation, neurosurgery, and cancer treatments. The Turkish medical tourism market offers high standard services in areas such as hair transplant, cosmetic procedures, and eye treatment. These patients finance medical services out of pocket. The cost of a service is basically market-regulated. Although the Ministry of Health has introduced a Bulletin of Health Application (upon which

private hospitals have the chance to alter prices up to 200 percent) for all available operations in private hospitals for domestic patients, there exists no regulations determining the prices for medical tourists. The prices are basically determined together with the private insurance companies. Invoices for the services are prepared on regular market terms.

The health of the tourist is a concept put forward for tourists who consult emergency services or get treated without prior planning. These patients are regular tourists who come to Turkey for touristic purposes and apply to a health service under unexpected circumstances. They prefer public hospitals in such cases and are regarded as a group out of medical tourism. However, due to the fact that they are considered as international patients, there exists policies regulating their conditions.

The third group of patients consists of foreigners that come to Turkey through bilateral health agreements. The basis upon which these agreements are made is rather political for the purpose of maintaining further cooperation with other states in the health sector. Collaboration on medical trainings, improving healthcare infrastructures, developing common projects to enhance medical systems are among the objectives of such agreements signed between Turkey and other states such as Austria, Denmark, Belgium, Egypt, Syria and Russia. Within this framework, Turkey offers free health services to a certain number of patients from less developed countries such as Sudan, Afghanistan, Yemen, Albania, Kosovo, Azerbaijan, and Northern Cyprus.

Their treatments are programmed by the Ministry of Health and patients are sent to certain hospitals with an official document. Although these patients are considered as international patients, they remain beyond of the scope of medical tourism since they are financed by the state.

The last group of international patients are mostly the diasporic component.

They travel to Turkey by means of agreements between social security institutions. Within the scope of social security agreements, migrants living abroad may benefit from healthcare services in Turkey. They are first financed by the Social Security Institution in Turkey and their payments are later received from related security institutions in Europe. As of 2012, Turkey had social security agreements with Germany, Austria, the Netherlands, Belgium, France, Northern Cyprus, Macedonia, Romania, Albania, Bosnia Herzegovina, the Czech Republic, Azerbaijan, Luxembourg, and Croatia.

As seen, the categorization of international patients is based on the ways in which they are financed. Although the “health of the tourist” and patients of bilateral agreements have no significant financial returns for the industry, they help improve Turkey’s political image in international relations and help advance the conditions of public hospitals. As regular tourists rather opt for public hospitals in cases of emergencies, the Ministry of Health has taken some initiatives to regulate the processes of medical consultation. Hence, it is important to underline that the activities of medical tourism and health of the tourist are two distinct areas and numerical analysis are carried out accordingly.

In 2012, the revenues of medical tourism were almost US \$2 billion, whereas (health of the tourist brought US \$237 million.)¹⁰⁷ The 10th Development Plan targets to receive 750,000 medical tourists and increase the revenue to US \$5.6 billion in 2018, which corresponds to a significant increase both in the number and revenue in medical tourism.

In addition to the financing of medical tourism activities, the finance of

¹⁰⁷ "Türkiye Medikal Turizm Değerlendirme Raporu 2013" (Ankara: T.C. Sağlık Bakanlığı, 2013): 77.

promotion, infrastructural capacities, intermediary services, and financial incentives are an important area of inquiry.

As in the regulation and monitory aspects of the industry, the state undertakes substantial support also in the financing of certain services. As the growth of the industry is strictly bounded to the promotion of medical tourism facilities, there exist significant efforts in this area. It is suggested to perform international promotional activities and establish a Health Tourism Promotion Fund under the supervision of the Council in 2010.

Apart from the initiatives of the Ministry of Health, the Ministry of Economy put forward an inclusive bulletin numbered 2012/4 on supporting the foreign exchange earning services trade, which made the Ministry of Economy a crucial actor in the maintenance of the medical tourism market. The basic purpose is to increase the foreign exchange earning services income and improve the competitive capacity of health tourism activities operating within Turkey. A certain amount of expenditures regarding health tourism are provided by the Support and Stabilization Fund. This fund supports several fields such as entry to the market, international promotion and consultation.

In accordance with the bulletin, advertisement and promotion activities are partially financed through various means. Sponsorship, advertisement, consultation and participation in foreign fairs, congresses and conventions are reimbursed at the rate of 50 percent and it could be up to US \$300,000 annually for health establishments and health tourism operators.

Within the scope of the bulletin numbered 2012/4, the following items are supported in health tourism initiatives: sponsorship, translation, rent expenses, advertisement on mass media, public relations, participation costs, advertisement

materials, and consultation expenses. In addition, there is another article very similar in content with regard to the participation costs in suggested foreign fairs, congresses and conventions by the state parties. Health establishments and health tourism operators are financed at the rate of 70 percent and up to US \$15,000. They can apply no more than 10 times in a year.

In addition to supports in conference attending for promotion purposes, the Ministry of Economy also endorses advertisement and promotion activities on search engines, including searching network ads. This amount could be up to US \$100,000 per year and at the rate of 50 percent.

The improvement of infrastructural capacities is a significant component of financial assistance provided by state funds. There has been important attempts to advance the physical and technical infrastructure of health tourism facilities on policy and practical levels.

On policy level, the 10th Development Plan states that construction plans and geothermic water distribution systems would be constructed between the years 2015-2017. Although it falls under the category of thermal tourism, it is a crucial case of how state provides necessary infrastructural necessities for the growth of the industry.

On the other hand, the establishment of free health zones signifies the ways in which the Ministry of Health takes charge in building the necessary physical areas for medical tourism amenities. The establishment of free health zones for the purpose of accelerating the inflow of foreign direct investment and advanced medical technology was enabled with decree Law No. 663.

As indicated in the law, the basic aims of these complex health facilities are to expedite foreign direct investment and advanced medical technology as well as increase employment and qualified foreign health personnel (brain drain). They are

composed of hospitals, rehabilitation centers, thermal tourism facilities, holiday villages for the elderly, research and development centers, health techno parks and recreational areas. Even though there is no free health zones in operation at the moment, the Ministry of Health envisages launching four zones by 2017. These zones also facilitate basic bureaucratic procedures both for operators and investors. Operators are exempt from paying certain taxes such as social security premiums, corporate income tax, and value added tax.

Advantages and incentives are applied to domestic and foreign investors at equal levels and investors are given shorter application and activity processes. Foreign investors are provided with cheap infrastructure and investment opportunities. In these areas, foreign health personnel (doctors and nurses) could be employed and 85 percent of the patients are aimed to be medical tourists. Consultant foreign doctors could also obtain short time employments without working permits.

As Turkish patients are aimed to constitute 15 percent of all patients, there will be no agreements with the Social Security Institution. Accordingly, the promotion of such areas will be in foreign languages targeting international patients. Another important aspect of the Free Health Zones is the practice of the Turkish fiscal responsibility and malpractice insurance legislation.

The idea of building free health zones is not confined to Turkey. Countries who strive to become medical tourism hubs appeal to such large scale projects. Mexico, Brazil, Saudi Arabia and Panama are among the countries that plan to establish free health zones.

The first city to build a free health zone was Dubai. Although it cost a great deal, expectations could not be met in terms of revenue and number of patients. They failed to attract qualified health personnel from abroad. Moreover, due to the high

costs of medical treatments, the number of patients remained far from the expected levels. Low investment rates emerged as another issue that raise doubts.

Intermediary services also receive significant financial support from state funds. As these services such as consultancy and documentation are crucial for the operating of medical tourism establishments, the Ministry of Economy provides assistance in receiving such materials. Bulletin numbered 2012/4 on supporting the foreign exchange earning services trade, envisages documentation support to health institutions on expenditures concerning international legislation.

Moreover, documents, certificate and accreditation that are obtained for the entry to foreign markets are also financed at the rate of 50 percent and up to US \$50,000. However, it is compulsory to apply to agencies addressed by the Ministry to obtain financial assistance.

Financial support to consultancy is obtainable. Health institutions and health tourism operators can obtain consultancy in marketing strategy, accreditation, and foreign market structure and their expenses are covered at the rate of 50 percent and up to US \$200,000 per year. They can get consultancy services from firms accredited by the Ministry of Health.

As incentives are a major component of investments, there exist various financial incentives for those who operate in the medical tourism market. The Ministry of Finance and the Ministry of Economy both have carried out legislations that facilitate certain proceedings. With the Law No. 6322, revenues from health tourism activities are given a 50 percent tax reduction. On the other hand, the Ministry of Economy provides financial incentives in entry to the market and foreign offices.

Newly established health establishments and health tourism operators are financed in reports about sectorial or international legislation up to US \$100,000 and at

the rate of 60 percent. Interestingly, the airline costs of medical tourists from countries indicated by the Ministry of Health are covered up to 50 percent. However, this amount may not exceed 20 percent of the total treatment cost and US \$1000 per patient.

Foreign offices are also encouraged by the Ministry of Economy as medical tourism is considered an export item. The rent expenses of these offices are financed for four years. In this respect, health establishments and health tourism operators may be covered up to US \$200,000 and at the rate of 60 percent per unit, annually.

The Provision of Medical Tourism Services in Turkey

The delivery of medical tourism services is provided both by public and private hospitals. In this sense, the private sector emerges as a crucial actor in delivering healthcare services to medical tourists. Considering the for-profit nature of the industry, it is no surprise that private hospitals hold a greater share in the provision of medical tourism industry. Public hospitals arise as the second group of hospitals that deliver medical services to international patients.

Table 4. Number of International Patients by Hospital Type, 2012

Public Hospital		Training and Research Hospital		University Hospitals		Private Hospitals	
No. of Hospitals	No. of Patients	No. of Hospitals	No. of Patients	No. of Hospitals	No. of Patients	No. of Hospitals	No. of Patients
308	27355	66	13042	26	3507	499	218095

Source: Ministry of Health, Evaluation Report on Medical Tourism in Turkey
http://www.saglikturizmi.org.tr/yonetim/templates/addons/ckfinder/userfiles/TMTD_2013_raporu.pdf

Along with regulation and monitory duties, the Ministry of Health also assumes responsibility in the provision of healthcare services to international patients, albeit to a limited degree. However, it is important to note that these patients are classified under the group of “health of the tourist” indicating that they remain outside of medical tourism. Those who stay in Turkey for touristic purposes and consult emergencies or health units during their stay are included within this categorization. At this point, it is stated “the presence of the state as a provider is obligatory since there is an increase in the number of foreign patients consulting emergencies.”¹⁰⁸

Table 5. Number of International Patients by categorization and hospital type, 2012

Hospital Type	Categorization of International Patient								Total	
	Bilateral Health Agreement		Medical Tourism		Social Security Agreement		Health of the Tourist		No.	%
	No.	%	No.	%	No.	%	No.	%		
Public Hospital	8	1.5	8235	4.9	3328	15.5	15,784	22.4	27,355	10.4
Education and Training Hospital	534	98.2	4586	2.7	2679	12.4	5243	7.4	13,042	5.0
Private Hospital	0	0	154,696	91.3	15427	71.7	47972	68.1	218,095	83.2
University Hospital	2	0.4	1945	1.1	96	0.4	1464	2.1	3507	1.3
Total	544	100	169,462	100	21,530	100	70,463	100	261,999	100

Source: Ministry of Health, Evaluation Report on Medical Tourism in Turkey, http://www.saglikturizmi.org.tr/yonetim/templates/addons/ckfinder/userfiles/TMTD_2013_raporu.pdf

¹⁰⁸ “Yabancı Hastalara Sağlık Hizmeti Sunumunda Kamu Hastanelerinin Rolü Raporu” (Ankara: T.C. Sağlık Bakanlığı, 2011): 7.

On the other hand, patients who come to Turkey via bilateral health agreements receive treatment at public hospitals. They are financed by the government and sent to certain hospitals that are indicated by the Ministry of Health. In regions where private forces do not invest for profitability and productivity reasons, the state takes it as its own duty to improve capacity building.

In 2012, 43,904 international patients appealed to public hospitals. Although there was an increase in the services provision of public hospitals in medical tourism, the ratio still remains far from reaching private sector levels. Nine percent of medical tourism services are performed by public hospitals, whereas were six to be 6 percent and eight percent in 2008 and 2010, respectively. In 2012, 17 percent of all international patients were treated at public hospitals, including those who come via bilateral health agreements. Patients who come to Turkey through such bilateral health agreements are only treated in İstanbul and Ankara. In 2012, 72 percent of 544 patients received treatment in Ankara.

There are 894 public hospitals in Turkey including state hospitals (764), training and research hospitals (67), and university hospitals (63). 14,766 medical tourists, who opt for Turkey to receive treatment and pay out of pocket, preferred public hospitals in 2012, corresponding to nine percent of all medical tourists. İstanbul and Şanlıurfa appear as the cities that attract most patients to public hospitals within the scope of medical tourism. Şanlıurfa's geographic proximity to countries as such Iran, Iraq, and Syria is an important indicator for its popularity.

The involvement of public hospitals in the provision of health tourism is projected to rise with city hospitals. Based upon the model of build-operate-transfer, city hospitals are a good example of public private partnership. City hospitals include maternity and children's hospitals, physical therapy and rehabilitation hospitals,

oncology and mental health hospitals. Along with such medical units, city hospitals also include hotel and social services equipped with high tech infrastructural capabilities.

Private hospitals, on the other hand, undertake the responsibility of provision to a large extend. 91 percent of medical tourists and 83 percent of all international patients were treated in private hospitals in 2012. Moreover, 68 percent of patients within the classification of “health of the tourist” consulted private sector hospitals.

The expansion of the private sector in healthcare services was also reflected on the medical tourism industry. The number of private hospital visits grew at a rate of 63.5 percent between 2002-2012. The government has actively supported the involvement of private sector in the national healthcare provision by including private hospitals in the social security plan, which in turn has created a basis upon which medical tourism could situate.

There are 499 private hospitals in Turkey. Medical tourists mostly opt for private hospitals that are in cities that also offer touristic facilities. 154,696 medical tourists preferred private health institutions in 2012, whereas the number was 15,426 and 47,972 for patients within social security agreements and health of the tourist, respectively. In the table below, it is possible to see that tourism assets and geographical proximity constitute the two basic factors for medical tourists.

Table 6. Top 10 Private Hospital preferred by Medical Tourists, 2012

Hospital Name	Number of Patients
Anadolu Sağlık Merkezi Hastanesi	12,229
Özel Alanya Anadolu Hastanesi	6918
Özel Akdeniz Hastanesi	6882
Medical Park Bahçelievler Hastanesi	5647
Acıbadem Maslak Hastanesi	5251
Medical Park Göztepe Hastanesi Kompleksi	4777
Özel Bilgi Hastanesi	4755
Dünya Göz Hastanesi Ataköy	4439
Medicana International Ankara Hastanesi	4422
Özel Bayındır Hastanesi	3535

Source: Ministry of Health, Evaluation Report on Medical Tourism in Turkey, http://www.saglikturizmi.org.tr/yonetim/templates/addons/ckfinder/userfiles/TMTD_2013_raporu.pdf

Another important dimension in medical tourism is accreditation. The Joint Commission International (JCI) provides accreditation for hospitals, ambulatory care, clinical laboratories, clinical care, medical transport and primary care services. Turkey has a high number of JCI accredited organizations. Between 2002-2013, the number of JCI accredited hospitals increased by 88 percent and reached 47 in 2013. As accreditation plays a major role in attracting medical tourists, private hospitals strive to complete such procedures.

In this chapter, an analytical framework of medical tourism in Turkey is provided in reference to the role of state institutions. The main actors of the expansion of the industry were elaborated with regard to their primary responsibilities and objectives. In this sense, one can argue that the medical tourism market in Turkey has been created and is further sustained by the support of state agencies.

In the conclusion chapter, a general framework on the development of medical tourism will be given. The underlying factors that gave rise to the emergence and development of the industry will be discussed from within an analytical framework. It

is also crucial to understand how local and global forces have created a space for the expansion of medical tourism. In this respect, welfare debates and health systems will be elaborated with particular attention to the Turkish case, alongside with the medical tourism dynamics in Turkey.



CHAPTER 6

CONCLUSION

The basic purpose of this study was to reveal the in which medical tourism has been emerged. It was argued that medical tourism in Turkey has been facilitated by economic and cultural globalization, which denotes free movements of goods and services and familiarity with other cultures. In addition, transformation in healthcare services paved the way for a different conceptualization of welfare services, particularly of health. Turkey, along with other developing countries, strives to establish medical tourism as an export item by targeting international patients and offering them low-cost and high quality health services.

State agencies have taken active roles in the regulation and monitoring of the markets. Contrary to what has been widely discussed about the retreat of the state from the scene, the state sustains its role as an authority in every aspect of medical tourism. Alongside of the state, the private sector and NGOs undertake important roles in the industry, private sector being the primary provider of health services.

Welfare regimes and healthcare systems were discussed in their broader relationship to the growing acceptance of health as a commodity. Along with global economic and political forces, the thesis focused on the development of medical tourism in Turkey, and its basic aspects such as governance, finance, and provision.

The growth of medical tourism has been enabled by economic and cultural globalization. The flow of goods and services became easier with economic globalization, which is a process that denotes interdependency among the markets and liberalization.

Under the provision of GATS, which came into force in 1995, health has become a global service sector which promised substantive growth rates. Within this newly emerging market, the flow of pharmaceuticals, medical devices, health personnel and patients became possible.

Governments strive to bring foreign exchange into the country through medical tourism, both by medical tourist revenues and foreign direct investment. In line with these, developing countries place medical tourism at the heart of their economic development since the industry required the involvement of several sectors such as tourism, airlines, health and trade.

First World countries also contribute to the growth of medical tourism, albeit pursuing different goals. Together with the constriction of welfare regimes, which created a space for the increasing involvement of private mechanisms, governments shifted health to one's own responsibility.

Health services thus go beyond the scope of welfare services. However, it is crucial to note that there exists discrepancies between the health systems of countries. Even though there is a general tendency to integrate the private sector in health services, including ambulatory servicing and pharmaceuticals, the degree to which it is implied varies among countries.

Developed countries support the growth of the industry basically to decrease the health budgets on governments, and eliminate long waiting lists. In countries such as the UK and Canada, patients have to wait long periods to receive certain medical treatments. In the US, the cost of a complex medical surgery, such as a heart bypass, is almost ten times more expensive than in a developing country.

Given such systemic problems, governments and insurance companies opt for medical tourism facilities in developing countries where tourism assets and Western

educated health professionals allure patients. Such practices, mostly organized by insurance companies and tourism agencies, were labeled as medical outsourcing and it promises great relief for health budgets in First World countries.

Ideological changes also influenced the ways in which healthcare systems were transformed. Along with the neo-conservatist approaches, public services were entitled as infertile, and the private sector was considered as a solution for the ungainly functioning of the public institutions.

The neoliberal restructuring of the world economy and increasing integration of world markets have been effective within this transformation. The institutional basis of the integration was configured with GATS in 1995. The primary purpose of this agreement was to liberalize trade in services. Thus, health became an important service sector the components of which such as medical devices, health personnel, and patients, could move freely. The development of medical tourism has been enabled within such a global structural context.

It is possible to argue that medical tourism is a multifaceted industry. The tourism sector appears as the leading industry that acts both as a facilitator and beneficiary in the growth of medical tourism. Brokers, conferences, media and website providers, insurance companies and consultation agencies have emerged as parts of a hybrid economic composition of formal and informal sectors. To what extent these areas could be institutionalized and benefit from qualified labor force remain important areas of inquiry.

One important feature of medical tourism is the growing support from governments. As previously discussed, developing countries and First World countries have varying claims over the expansion of the industry. Most developing country governments regard medical tourism as part of their economic development and

introduced certain policies that help its expansion.

Medical tourist visas, reduced tariffs on imports, and tax-deductible land given to investors, collaboration with the private sector firms for trade fairs and conferences, and reduced airplane tickets are among the strategies that governments adopt to increase the number of medical tourists and foreign investors. In this respect, financial and promotional assistance are given to medical tourism providers. As such, the medical tourism market is created and further sustained by state actors. The authority and legitimacy of the state continue to be influential on the economy.

In Turkey, medical tourism has emerged in line with its developing counterparts. Based on exploiting the rising health expenses in Western countries, Turkey strives to become a medical hub that offers qualified and low-cost medical treatments. Government policies regard medical tourism as an export item and place it as part of its economic development goals. In this respect, the collaboration between public and private sectors is given significant emphasis.

State agencies assume responsibility in infrastructure development and financial support to investors. More importantly, government bodies restrict their own roles to governance and monitoring and concede the provision of medical tourism to the private sector. A series of legislative acts have been put forward to enable private hospitals to act as main providers of medical tourism services. Moreover, the institutional basis of the industry was set in 2003 by the Health Transformation Program in 2003.

Within these reforms, the Ministry of Health was restructured and withdrew from health provision. It was redesigned as a regulator and supervisor. It is through such regulations that a health tourism office was established within the Ministry of Health to organize medical tourism activities. Also, government started to purchase

health services from private hospitals, which enabled them to become important actors in healthcare provision. Private hospitals were strengthened with local patients, and aspired to become medical tourism units in the meantime.

As Turkey has acquired a strong position as a medical tourism hub, some important social policy issues have been raised. In parallel with the development debates in other developing countries, to what extent medical tourism could promote development is an area of major questions. Although medical tourism is regarded as a blessing to the economy, it could bring certain problems to the national health systems. The brain drain appears crucial within this debate. Qualified health professionals may prefer working at better-paying private hospitals and a labor deficit could occur in the public health systems. The internal brain drain is considered a significant concern and raises questions about recovery for local patients. However, the lack of qualified data on Turkey in this area preclude developing such a debate. It is certainly crucial to make further academic research to understand as to whether medical tourism could promote development in Turkey.

Considering the profit-driven character of the industry, medical tourism should be addressed within a broader scope, including economic, political, and ideological factors. The development of the industry is a process created by the liberalization in healthcare systems. Although most of the literature focus on the economic aspects of medical tourism, social policy implications remain of great importance for the future of welfare regimes.

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