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NEOLIBERAL TRANSITION IN HEALTH SYSTEM IN TURKEY: THE CASE OF THE CITY HOSPITAL MODEL

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TÜRKİYE'DE SAĞLIK SİSTEMİNDE NEOLİBERAL DÖNÜŞÜM:
ŞEHİR HASTANELERİ MODELİ ÖRNEĞİ

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This study is dedicated to the memory of Zafer Açıkgözoğlu who passed away as a subcontracted health worker in 2014.

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LIST OF ABBREVIATIONS

PPP: Public Private Partnership

JDP: Justice and Development Party/Adalet ve Kalkınma Partisi

AKP: Adalet ve Kalkınma Partisi/Justice and Development Party

AP: Anavatan Partisi/Motherland Party

DSP: Democratic Left Party

MHP: Nationalist Movement Party

TÜSİAD: Turkish Industry and Business Association

IMF: International Monetary Fund/Ulusalararası Para Fonu

EPEC: European PPP Expertise Center

TÜİK: Türkiye İstatistik Kurumu/Turkish Statistical Institute

WHO: World Health Organisation

WB: World Bank

SSK: Social Insurance Institution

SGK: Social Security Institution

BAĞ-KUR: Tradesmen and Craftsmen and Other Self-Employed Social Insurance Institution

DİSK: Confederation of Progressive Trade Unions of Turkey

DPT: State Planning Organization

ABSTRACT

NEOLIBERAL TRANSITION IN HEALTH SYSTEM IN TURKEY:
THE CASE OF THE CITY HOSPITAL MODEL

While the health system has been sharply undergoing a whole series of changes in the world and Turkey, the assessment of capitalist relationships in the background of these changes is being aimed at critical political economics arguments. In this regard, Health Transformation Program, implemented by Justice and Development Party since 2003, is the focal point of the study. Besides, the Public-Private Partnership Model that has been profoundly led to transform in the provision of public services, in the meantime, it has also been penetrating the health system is examined in the thesis. The City Hospital Model, which is the second phase of the Health Transformation Program, is the latest example, and it is evaluated as a fact in the research. The study has been comprehensively containing the legal, political, and economic context of City Hospitals that have been built by the Public-Private Partnership Model. The dissertation, fundamentally, concludes that the City Hospitals continuing to be built by the Public-Private Partnership Contracts does not mean the right to health having equal access; these are the lucrative areas of investment and capital transfer for the contractor companies.

Keywords: Marketization, Privatization, Commercialization, Commodification of Health, City Hospitals

ÖZET

TÜRKİYE'DE SAĞLIK SİSTEMİNDE NEOLİBERAL DÖNÜŞÜM:

ŞEHİR HASTANELERİ MODELİ ÖRNEĞİ

Sağlık Sistemi dünyada ve Türkiye'de keskin bir şekilde bir dizi yapısal değişikliklere uğrarken, bu değişikliklerin arkasında yatan sermaye ilişkilerinin eleştirel siyasal iktisadın argümanları ile değerlendirilmesi amaçlanmıştır. Bu bağlamda AK Parti'nin 2003 yılından beri tam olarak yürürlüğe koyduğu Sağlıkta Dönüşüm Programı çalışmanın odak noktasıdır. Devletin kamu hizmetleri sunumunda köklü dönüşümlere yol açan ve sağlık sistemine de nüfuz eden Kamu Özel İşbirliği Modeli bu tezde incelemeye tabi tutulmuştur. Sağlıkta Dönüşüm Programı'nın ikinci fazı olan Şehir Hastanesi Modeli ise Kamu Özel İşbirliği'nin en güncel örneğidir ve bu çalışmada bir olgu olarak incelenmektedir. Çalışmada Kamu Özel İşbirliği Modeli ile inşa edilen Şehir Hastanelerinin yasal, siyasal ve iktisadi bağlamları kapsamlı şekilde yer almaktadır. Tez, temel olarak, Kamu Özel İşbirliği sözleşmeleri ile inşa edilmeye devam eden Şehir Hastanelerinin eşit erişime açık bir sağlık hakkı olarak değil, bir yatırım ve sermaye transfer alanı olarak yapıldığı sonucuna varmaktadır.

Anahtar Kelimeler: Piyasalaştırma, Özelleştirme, Ticarileştirme, Sağlığın Metalaştırılması, Şehir Hastaneleri

CHAPTER 1: INTRODUCTION

The initiatives for making reforms in health systems have globally been one of the far much-debated issues from the 1980s to recent years. The main reason that made this topic a current issue is that the health system is integrated into the new economic system. Even though the reforms vary from country to country, the basic purpose of these reforms, which have arisen from European countries and have been spreading the rest of the world, is basically to enhance efficiency and to shrink publics expenditures that have been swiftly soaring in the health systems. In addition to the similarity of these two aims and as a result of them, the reforms have commonly been enabling the countries to enlarge the scope of the healthcare system and to raise access to healthcare services.

Turkey has also been one of the countries who are willing to make reform in the healthcare system since the 1980s, in order to be integrated into the new global economic era. However, the period of integration into new global economics had been sharply realized by the governments in the power of the Justice and Development Party (JDP) since 2002, when it won its first election. Moreover, one of the most significant factors that led to JDP's winning the general election in November 2002 was its election promise regarding the health system. The name of the reform in the health system which the Justice and Development Party has been promulgating and implementing since 2003 is the Health Transformation Program. The Health Transformation Programme contained vast broader changes than the past reforms, including health tourism, provision of healthcare services, pharmaceutical industry, healthcare staff personal rights, the administrative structure of healthcare, privatization of health, etc. Besides, the Health Transformation Programme is a process that has been continuing to implement a variety of laws until today. It consisted of two phases: The first phase is called the "Health Transformation Project", which was initiated in 2004, and the second phase

is called the “Health Transformation and Social Security Reform Project”, which was initiated in 2009. There have been a series of changes, such as several regulations and laws in both phases.

The Health Transformation Program was declared to the public as “A Revolution in Health System”. That conceptual discourse choice was actually not wrong due to the fact that the old system enormously created victimization. Turkish press used to write in newspapers the news related to people forced to pay ‘knife money’ to have an operation, people waiting in line at the gates of hospitals, or patients being taken hostage at the hospitals.

Turkish welfare regime was not comprising citizenship-based universality before Health Transformation Program in terms of access to health. The population was fragmented into hierarchical groups according to employment conditions. Those who needed healthcare service were able to benefit from health in compliance with hierarchy. The hierarchy also was based upon the vocation as well as premium.

The uppermost of the hierarchy were public officers. The hierarchy went from top to down as self-employed ones, workers, and those who are officially registered as poor people, respectively. The establishments of these layers have been, respectively State Retirement Fund (SRF), Social Security Organization for Artisans and the Self-Employed (SSOFASE), Social Insurance Institution (SII), and Green Card. Those in the last group who were registered as poor and had green cards had only the right to access healthcare services. In this framework, the system also did not contain the people who could not pay the premium, who did not have any health security and were in the rest of these layers.

Furthermore, Health Facilities also had been fragmented. Even though SRF, SSOFASE, and SII belonged to the state, they were being acting autonomously. Thus, healthcare service has differentiated, and inequality in service has shown an upward trend. The fragmentation among health facilities also brought about incoordination between doctors, hospitals, and the other units, and this incoordination had adverse impacts on the provision of healthcare service. For instance, the hospitals belonging to Social Insurance Institution were crowded due to excess demand. That resulted in crowds of people waiting in lines at the gates of the hospitals. However, the hospitals belonging to Social Security Organization for Artisans and the Self-Employed or State Retirement Fund were providing service with vacant capacity. It means that accessibility was not equal.

In addition to all these, the situations in which people had to pay prices called 'knife money' for surgery notwithstanding insurance premium, and had to buy surgery equipment, and had to wait in lines at the gates of the hospitals for clinical examination were major problems. The people staying out of the system could not benefit from anything concerning healthcare services.

Within this process, the Justice and Development Party won the election in the company with an election promise regarding the change of the healthcare services. It publicly announced Health Transformation Program in 2003. The significant change was the annihilation of fragmentations among institutions providing healthcare services. However, this change did not include the premium system. It was based upon access to health. Thus, all citizens would have been able to reach healthcare services in the hospitals where they wanted. Besides, the program aimed at expanding the scope of social security. The overwhelming majority of the population, hereby, would have been covered under social security. These were vital breakthroughs especially for those who were extremely vulnerable in terms of not having any social security. Access to decent healthcare services for the people

who are workers belonging to Social Insurance Institution meant that the most significant needs were addressed.

In the light of these improvements, the Health Transformation Program was noticeably delivering outstanding performance according to the mainstream media. Therefore, that tangible changes had been called the “Revolution in Health”. However, the program did not only include accessibility, but also included substantial corporate and structural changes in the healthcare system, and these are, too, continuing today.

Within this context, my intention to study this thesis has emerged. There is no denying that Healthcare Services has been undergoing a major change. However, health and healthcare were now defined as a commercial service, contrary to the conventional wisdom in public opinion. It would have dramatically led to vast quantities of transition.

This transition is mainly based on the idea that health is a commodity which is sold and bought in the market, and beneficiaries of healthcare are illustrated as a consumer. Moreover, accessibility to health does indeed mean being able to make a selection from a private hospital to the other, just as that the market mechanism has been working. The approach that people must be consumers of healthcare rapidly became a significant part of the Turkish agenda during the Health Transformation Programme. Besides, health has been called a 'sector' in daily discourse, because it has been accepted that citizens are consumers.

Within this framework, briefly, that study is largely going to focus on healthcare services, which have been started to be seen as an investment area. It will discuss Justice and Development Party era and Health Transformation Programme as a fact

that has been by far the most popular development after 2003. The case study of the research is City Hospitals which has been a unique opportunities area for capital investment.

In this regard, this thesis will discuss Health Transformation Program in the context of commercialization, privatization, marketization, and commodification. The focal point of the thesis is basically Health Transformation Programme. However, the thesis will be more specifically explaining the City Hospital Model that is a part of the Health Transformation Program Second Phase. The analysis will unveil the mystery of the City Hospitals thanks to the fact that capitalist profit maximization outweighs public health and equal access to health, in the light of the critical political economy approach. The thesis would be analysing the City Hospitals in particular and neoliberal transformation in Turkey in general.

Justice and Development Party Government has announced City Hospital Model to the public that it would have been built and serviced without paying any penny of the national treasury. Thus, new huge and glorious hospitals would have been built and the number of hospital beds would have increased and, the new and high-quality types of equipment would have been in service. Therefore, this City Hospitals would have been an impressive achievement in health. The instrument of the building City Hospitals without any payments has also been Public-Private Partnership Contracts.

In this case, my intention to study City Hospitals deeply in the framework of the Health Transformation Programme emerged. City Hospitals built with Public-Private Partnership Contracts allow mainly the contractor companies to increase the radius of action in health and healthcare services. According to the contracts, they construct the hospitals and operate for approximately 25 - 30 years. However, it does not mean altruism. In this process, in return, the government and its Ministry

of Health have been making some concessions to the contractor companies as encouragement. In addition to the privileges stemming from contracts signed between the state and contractor companies, the legal and financial regulations also lie behind these concessions. The significant major concession is the payment of rent financed by the budget of the Ministry of Health.

Coming from this framework, the dissertation employs the framework of critical political economy insights in order to find out the capital transfer, within the context of health, in the neoliberal economy that we are exposed to recently. The thesis research related to The Health Transformation Program and its significant component, City Hospitals, which are glamour investment areas, will basically criticise the vital role that profit maximization plays in even human beings' basic needs and the state budget. In this regard, Public-Private Partnership Model will be scrutinized as the commodification and privatization of health. Therefore, the study will be interrogating City Hospitals in the light of the core question, "Why has the Public-Private Partnership Model in Healthcare Services been overweighing since the beginning of the Justice and Development Party era?"Furthermore, there are sub-questions to lay the role of neoliberalism in health and enlarge the research with references to the critical approach. These sub-questions of the study are as follows: What motivation had Health Transformation Program emerged at the beginning of the 2000s? Why have Healthcare Services been starting to be seen as an investment area in Turkey? How does Public-Private Partnership Model in healthcare work in Turkey? What are the political dynamics and choices under public-private partnerships in healthcare services? Why have been City Hospitals adopted as the long-term provision of healthcare services?

The thesis draws mainly on critical thought within the context of the marketization of health. The issue of marketization of health is generally tackled as Health Management and Health Systems in the Turkish context. In addition to this twofold

title, Health Transformation Program is predominantly considered as efficiency or performance. Even if there are several studies about the Health Transformation Program with references to the notion of critical political economy, there is barely any critical research about City Hospitals due to the fact that they have been constructed lately. This study, in this regard, will be contributing to the literature. The critical approach enables the thesis to form the structural frame regarding the Public-Private Partnership model in general and the City Hospitals in particular. Thus, the thesis will be unmasking that the City Hospitals have been posing serious challenges to healthcare services and the public budget and they have been delivering outstanding performance only for contractors companies, not for the citizens. Besides, the thesis will underline that Health Transformation Program and its component City Hospitals have been sharply undermining the equal right to health as a matter of equal citizenship. More precisely, it is, first of all, keen on defending that healthcare services should be entitled to free.

The methodology of the research is basically going to be based on the primary sources, which are the reports and statistical analysis of national or international institutions such as the Turkish Statistical Institute (TÜİK), Turkish Medical Association (TTB), World Bank (WB), and International Monetary Fund (IMF). In addition to these, the statements and figures of the Ministry of Health of the Republic of Turkey have been a fundamental resource. The thesis is based upon economic data and its interpretation by critical and mainstream approaches. There is an extensive corpus ahead of us corresponding to the 'Health Sector' and its components within this context. There are pretty much conflicting views related to it. The study has mutually analyzed these views. Nonetheless, its purpose is criticism of the City Hospitals, which are built by the Public-Private Partnership Model. The research has eagerly revealed what Public-Private Partnerships (PPP) Model means, which drastically enabled capitalists to derive huge profits. Therefore, it focused on contracts between government and contractor companies, their terms and concessions, and practices in Turkey and abroad. Yet, there is a

severe obstacle at this point. The Contracts of Private Public Partnership has not been publicly and specifically announced due to 'trade secret' in Turkey. Consequently, we cannot reach the details of the terms of the contracts, such as guarantees given. They are basically contracts of tenancy which has long-term effects, and they, therefore, must be transparently announced. Despite the fact that the details of the contracts cannot be reached, the points such as the amounts in annual reports of State Audit Court, allocation from the budget for these contracts, the rise of the allocation every year etc. have made a significant contribution to the thesis. Therefore, the thesis was drawn on State Audit Court's annual reports and have advocated its arguments according to these numbers. Besides, the thesis also referred to the reports and statements of the Directorate of Strategy and Budget of Presidency of the Republic of Turkey, the explanation of the Members of Parliamentary and the news on the media.

Due to the fact that the City Hospitals are a new case in Turkey, the research does not include a field study such as in-depth interviews. However, it comprehensively tried to do a literature survey. In this regard, another source of the thesis is international examples of Public-Private Partnerships and their reflections on healthcare services primarily in Europe. Public-Private Partnership Model had emerged in the United Kingdom at the beginning of the 1990s and disseminated rapidly worldwide. That is why the PPP experience of England in Healthcare and the reports of British Medical Association have inspired this study in order to defend their arguments. In this regard, the thesis has also tried to shortly discuss similarities and differences between Turkey and the other countries.

Finally, the dissertation advocates that health and access to health is an invaluable human right. In this sense the critical social sciences paradigm constitutes tangible structural framework of the thesis and thereby the criticism of neoliberalism is the most major reference guide. The resources of critical theory, which consists of the

arguments such as accumulation regime and crisis theory have advanced the arguments of the study and offered an insight into the study. Briefly historical background, written sources, theoretical arguments, statistical data, reports and legal and political decisions have catered for that the thesis seeks the answers to this research question. The main study context of the thesis is City Hospital contracts based on Public Private Partnership, the burden that these contracts have been and will be creating on the state budget, and the capital accumulation process being realized in these contracts.

In this context, a theoretical discussion was made in the second chapter. The key concepts discussed in this section are, generally, the political and economic dynamics of neoliberalism, privatization, marketization, commercialization in health. Agendas such as 'governance' and 'structural adjustment' referred by decision-makers regarding the motto of neoliberalization are among the political subjects of the theoretical debate. The second chapter also amply demonstrates where the capitalist accumulation process became explicitly visible. In this regard, it is emphasized that health has been reliably becoming a sector as an investment and accumulation area and has been sharply diverging from the concept of human rights. Chapter 2 presents the literature review regarding commercializaton, marketization and privatization in healthcare services by constantly underlining capital transfer. The reason why it is done in the thesis is to emphasize that the private activity has been soaring, whereupon the investment in health has been drastically becoming widespread.

The third chapter is the historical part of the thesis. First of all, in this part of the research, the thesis focused on the historical facts of the emergence of neoliberalism globally. In this regard, it briefly explains that neoliberalism accompanied by regimes with abundant political pressure is not a coincidence. However, the fundamental point that chapter 3 widely explained is based on historical context in

Turkey, especially after the 1980 coup d'etat. In other words, the last 40 years adventure of neoliberalism, including newly introduced laws, concession contracts, etc., is significant in transforming the economy in Turkey. Health, being an investment area and have been opened to investment, is underlined in detail thereafter. Finally, by giving historical information regarding Social Health Insurance Systems, Chapter 3, besides, historically mentioned the type of welfare regime Turkey has been adopting and the type of health system Turkey has been integrating. The primary point which is reckoned is that the neoliberalization in Turkey has been exacerbating the disruption of the social and economic rights since its emergence.

The case study on the City Hospital Model is examined in chapter 4. Firstly, Health Transformation Program is analyzed as a fact, paving the way for City Hospitals. In this sense, Neoliberalism is frequently highlighted. Moreover, the point is that Neoliberal Health Reforms have been giving rise to making the healthcare services a profit maximization area in terms of the capital over the last two decades. In that process, the finance form and organizational structure of public hospitals have been gradually changing. That point is a milestone for the City Hospitals since Public-Private Partnership Model emerges.

City Hospitals have been constructed by Public-Private Partnership Model. Chapter 4 will be defending that Public-Private Partnership is the way of privatization, with the emphasis on rising costs and concessions. It is simply a kind of contract including 'the public' concept. However, it is a capital transfer from the public to the huge companies in the name of 'the public'. Regarding this view, this chapter will explain the implementation of the City Hospital Model with all its parts in detail. In other words, this part of the thesis has also deeply clarified that the literature should not be solely focused on city hospitals as huge and well-built constructions, with references to the framework of economic relations. This part

will be too much dedicating time to the political economy analysis based on that contractor firms which put their own profits ahead of public health within the context of City Hospitals.

The last part of the thesis is the conclusion based upon thorough assessments. Chapter 5 is offering consideration of reasons why the health transformation program emerged in general and the city hospital model was adopted in particular within the context of the research question. The conclusion vividly highlights that the transformation of health is not the road to access to quality healthcare services; it is commodification and privatization of health. This comment in the conclusion is coming from the reading, which is, transformation in health is in conjunction with the neoliberal transformation. In other words, the analysis is grasping enthusiastically the approaches related to neoliberal globalization and its reflection to local. To sum up, in the conclusion part of the thesis, the finance capital whose needs are addressed by state regulation and, the state regulation which has been working with it, in accordance with the case of City Hospitals, are discussed. In addition to the opinion that the thesis advocated, this chapter will be completing the study with questions that can be leading to future research interests.

CHAPTER 2: NEOLIBERALISM AND HEALTH

The structural, economic, and governmental transformation in the modern capitalist state has vividly been existing since the emergence, due to the fact that the modern capitalist state desires the new. The new means that it must generate a solution to economic crises inside capitalism, whereupon it is opened to investment in the new areas. Therefore, capitalism is a transforming economic and political order. The reason why it has been transforming is also related to the profit-maximization desire of the capitalists and to the need to protect this desire of them. Besides, in this part, I will be evaluating that hitherto the transformation of the modern capitalist state is related to the capitalist state's crises.

Although post-modern discussions mentioned that the state has deeper relationships these days, I will strongly defend in this research that the state is mainly the organization of the capitalist class. In other words, I am, thereupon, in this part, mentioning that the regulations, laws, and fiscal policies of the state cater to the capitalists. According to Marx and Engels, “The executive of the modern state is but a committee for managing the common affairs of the whole bourgeoisie” (Marx & Engels, 1998). In addition, I underline that the transformations of the modern capitalist state are according to the class benefit of the dominant capital fractions in the capitalist state as well.

The modern capitalist state has sharply been transforming in a global sense for four decades. This last transformation drastically affected the whole social and economic structure. The main motto of this period is financialization in all areas, and healthcare services have been thenceforth a glorious financial investment area.

The new economic order that was in a period of transformation for four decades, accepted and known as neoliberalism, has been fragmenting and destroying all social and economic rights, including healthcare as well, by commercializing, privatizing, and marketizing. Therefore, by examining neo-liberalization together with healthcare transformation, I benefit from a critical economic approach in the second chapter.

2.1. LIBERALISM – NEOLIBERALISM: A BRIEF OUTLINE

The bases of philosophical, political, and economic liberalism, which historically dig down deep of the 17th century, are in brief rest upon "Limited State". Liberalism can be defined as a doctrine that the individual and its freedom are vital, a free-market economy is untouchable and political freedom is necessary. The role of the state in liberalism is mainly to establish the regulation of the market. In this framework of regulating the market; private ownership, free trade, competition and free economic enterprise are being accepted as fundamental rights and freedoms. Another emphasis of liberalism in that macro-economics order is rationality that everybody advocates own benefits in the market. All those factors enable the competition to increase and thereby to go up the economic recovery and development. In the meantime, liberalism, within this scope, undoubtedly depreciates economic equality. Therefore, according to liberalism, the state must be limited and not interfere in the market. The liberal freedom approach underlines that everybody is equal and free to enterprise, not equal distribution within the context of equality.

In addition to economic emphasis, liberalism also has political content such as the superiority of law, right of succession, and fundamental political rights. These are regulated by the state. In this regard, liberal social order comprises of two main

headings; Liberal Economic Order which is named Market Economy, and Liberal Political Order which is named Liberal Democracy (Aktan, 1995).

Where the whole of these economic and political relations are concretized is being called the capitalist order. Nonetheless, the mechanism in which capitalist order concretizes is also the modern capitalist state. The liberal economic arguments and thoughts that are explained above based on the capitalist state have been discussing and becoming varied until today. The reason why they are done is related to that capitalism has financial crises and consequently being tried to generate a solution inside capitalism. Therefore, various liberal economic paradigms have dominated the world in various periods that economic crises have emerged.

That general framework of classical-liberal thought was criticized by Neo-Classical Economic Thinkers, seen as Welfare Economists. They have defended that social welfare will not be possible without state intervention. According to them, social welfare could not be realized because of not being able to pure competition model in real life and the existence of internal and external economies (Aktan, 1995). The state intervention in the economy is accordingly inevitable. Classical Liberalism has failed in the economic crisis in 1929. As a result of the failure in the economic crisis, J. M. Keynes had vividly advocated the market intervention of the state along the same lines. His solution recommendations are not only centered in the private sector, but also the state-driven macroeconomic politic theory, known as 'General Theory'. It is basically based upon a mixed economy for social welfare.

The interventionist state adopting protectionist policies as a way that copes with crisis had gradually spread across the globe after 1929 and was accomplished at continuing its existence in the global economy until the beginning of the 1970s since classical liberalism was susceptible to crises. With the adoption of state intervention, in the 1930s in the USA, the new policies had implemented, called

New Deal by President Roosevelt, and have aimed to mitigate destructive obstacles of the crisis, whose name is the accumulation crisis of liberalism. The basic purpose is to create demand under state control.

Keynesian broader definition related to state protectionism is that the state can make strong regulations to diminish the freedom of the market by limiting particular actors. This is because, if limitless market conditions dominate the capitalist system, crises will become indeed unavoidable, and they will thereby be irrecoverably jeopardized capitalism. According to Keynes, the main element of aggregate demand was investment expenditures, and in an uncertain world, the economic policy which has been charging low interest and thereupon aimed at full-employment was in vain. Therefore, the state must be intervening in the market to create full employment. He thinks that the 'invisible hand' of the market is unreliable and the state role must go up.

In Keynesian macroeconomic theory, known as demand-side economics, at the same time; the economic development and growth, fair income distribution, active and direct decisions of the state concerning aggregate demand curve, and economic stability are the main mottos (Güngör, 1998). The main purpose of the Keynesian economic model is, broadly, based upon the fact that the state is the founding actor of minimizing inequalities and creating a full-employment area. According to him, the crisis was inevitable for capitalism when the elbow room of the market, sharply, expanded. Keynes was recommending that the crisis could be prevented by intervening in the economic actors and structures in capitalist society. In a time of crisis, the state should have intervened to create demand by generating employment. Therefore, this economic model is called the demand-oriented economic model as well. Besides, that economic model of Keynes, named Welfare State as well, has tried to keep the economy as stable as possible by equating total demand equal with total supply and to keep away from barriers such as unemployment, which have

severe socioeconomic consequences. Thus, it did not hesitate to push up various expenditure items such as social security expenditures as well as infrastructure investments.

Within this period, albeit a destructive and destroyed war around the world between 1939 - 1945, Second World War, those economic policies have worked. Besides, before the war was over, an international meeting was held at Bretton Woods in 1944, led by the United States. The essential reason for the meeting was to recover the world economy that was destroyed by the war, to improve the economies that ended, and to continue the flow of money trade in the world as if there was no war effect. Therefore, the currency of the participating countries was adjusted to the dollar, and the dollar rate has been determined as the only currency that can be converted to gold. Besides, this meeting is the prototype for the establishment of significant institutions such as the WB and the IMF. This economic period, which has lasted strongly until the 1960s, has been called 'The Golden Age of Capitalism'.

Keynesian economic policies have met requirements regarding economic instabilities until the late 1960s. They positively influenced political areas such as increasing democracy, human rights and, social and economic rights, and creating full employment. Nevertheless, the steady rise of state intervention and, whereupon the vast increase of budget burden has given rise to budget deficits and, whereas the soaring the portion of those budget deficits as well. In addition, the fact that Japan has spread its market influences thanks to post-Fordist structuring, the growth rate has sharply declined in the USA and, thereupon, European economies had affected by it were significant signals which did prove new crisis (Daldal, 2010).

The alternative solution inside capitalism, known as neoliberalism, has emerged within this context and process. According to Harvey, capitalism is indeed too much accomplished at protecting and increasing its benefit and profit in the time of crises

that are resulted by itself. Thus, the market can be again dominated by capital distribution via 'creative destruction' (Harvey, 2007). In this regard, neoliberalism has been the trustworthy economic model for capital for disseminating its profit maximization.

When viewed from this aspect, neoliberalism is an effort of the capitalist class that has overcome obstacles of profitability crises of Keynesian Model and has built its class hegemony against Keynesian social and economic reconciliation.

2.2. THE MAKING OF NEOLIBERALISM

At first glance, even though neoliberalism only consists of economic approaches, contents and rules; it also has abundant political and institutional contexts and reflections likewise. That characteristics enabled it to survive until today. Therefore, neoliberalism ought to be explained within the economic, historical, and political context.

2.2.1. Historical Background

Although neo-liberalism entered the agenda of intellectual and political circles in the 1970s, the origin of the theses it defended can be traced back to the emergence of liberal economic thought at the end of the 18th century. The liberal economic thought is based on the concepts of the natural law of the Physiocrats, especially F. Quesnay, and the natural order of the market, free enterprise, and “homo economicus” by Adam Smith. These concepts also became current with the explanations of economic theories called neo-liberals. The development of the “minimal state”discourse, which is the basic argument of neo-liberalism today,

coincides with this period. The minimal state discourse, which dominated the field of economics until the 1920s, lost its effectiveness with the 1929 Depression, and afterwards, it was replaced by the Keynesian understanding of economics and the "interventionist state"model. However, the great depression of the world economy in the 1970s was considered as the bankruptcy of Keynesianism this time and the prescriptions of liberal thinkers were recalled. Thus, liberalism, which took the stage again, revived the classical discourse of the 18th century with the criticism that it developed against the welfare state, planning, and all kinds of state intervention by taking the prefix of 'neo' (Kazgan, 2014).

The indexation of currencies to dollars, which was the main idea of Bretton-Woods system, resulted in the failure of the system. The weakening of the US gold reserves caused a change in policy and the Bretton-Woods system collapsed in 1971 by declaring that it gave up indexing the dollar to gold. It ended the dependence of currencies on the US dollar on the exchange rate system. Thus, the intervention mechanism of Keynesian policies in money movements was terminated and the way for the speculative circulation of money around the world was opened (Daldal, 2010)

In 1973, the oil crisis appeared in OECD countries. In addition to the oil crisis, the increase in inflation and unemployment and the decrease in growth started to be shown as a reason for the discussion concerning usefulness of Keynesian policies. Besides, the negative influences of budget deficits in these countries were also attributed to Keynesian economic policies. Opinions that budget deficits have negative influence on aggregate demand management and that they have unstabilizng effects have started to gain importance. On the other hand, economists who defended supply-side economics theories began to underline that making balanced budgets that only cover budget deficits is not sufficient, and simultaneous downsizing of the state is necessary (Ergül, 2009). The reasons that created the

crisis were linked to Keynesian policies and the state's intervention into the economy, the expanding rights of the working class and high wages were also emphasized (Daldal, 2010).

With the sudden increase in oil prices, especially oil producing countries became rich with petro-dollars they earned from oil export. These countries lent loans to countries in economic crisis. In addition to European economies which were dependent on imported oil, other countries were also affected. Shocks were also observed in the economies of other central countries that accumulate through production. Reconciliation and negotiation processes within countries have replaced the requirements of the market in the new order. As a result of all these, the function of the nation-state that provided social integration has decreased. In the prevailing new economic model, nation-states now became states of competition. Institutional structures such as IMF and WB started to determine the conditions of this competition with their changing structure (Daldal, 2010). In the next period, projects would be developed under structural adjustment with WB loans in non-commercialized areas and these areas would be opened to investment.

2.2.2. The Economic Approach of Neoliberalism

Neoliberalism can be mainly summarized as the policies consisting of downsizing the state, cutting public spending, and limitless privatization; even though there are neoliberal approaches which differentiate in economic and politic terms, such as Neo-Austrian Economics School, Chicago Economics College and Constitutional Economics School. Their founding fathers are respectively F. V. Hayek, M. Friedman, and J. Buchanan. They have made the rotation of liberalism by far the most popular. Neo-Austria Economics School underlined the destroying effect of state intervention. According to Chicago Economics College, the reduction of money supply and tight monetary policy are vital breakthroughs. M. Friedman had

rigorously criticized the state intervention in monetary and fiscal policies, rent controls, minimum wage, and sectoral subsidies enforcement; because according to him, these practices have depleted market forces and prevent competition. According to Constitutional Economics School, in addition to downsizing of the state and cutting in public spending, individual freedoms must be guaranteed. In other words, economic freedoms, private ownership, and contract freedom are invaluable for the free market economy (Tayyar & Çetin, 2013). As seen, the approaches actually differ only in their details; they indisputably share common goals to make the free-market economy able to run efficiently.

Within this context, neoliberalism was actually inspired by Classical Liberalism's tangible economic arguments. However, neoliberalism has been economically and politically improving and surpassing classical liberal thought. Furthermore, neoliberalism is also the whole of the rules of Private Ownership, Free-Market, and Free-Trade which are internationally employed by the states according to their international division of labor and their international role (Gambetti, 2009). Social Welfare will be realized via these rules.

Keynesian economic policy was defending import substitution industrialization, and what is more, it was aiming to expand productive capital. However, neoliberalism has been noticeably reluctant to do that. The finance sector in the neoliberal model has outweighed compared with the Keynesian model. More clearly, the state did not only invested in the production capital, but what is more, the compound of public spending has also been changing. The defense and infrastructure investment has been becoming more and more important. The neoliberal formation is a transformation that had established accumulating regime according to financialization. Besides, it opened new areas such as education and health to investment by getting them included in financialization as well (Ergül, 2009). According to Gambetti, the determinant factor in neoliberalism is that real

production is replaced by finance capital in order to re-establish class power in the capital accumulation process (Gambetti, 2009). Within this frame, it seems that concessions and regulations going in the finance sector's favor are provided by state support.

The economic features of neoliberalism also often emphasize the contraction of domestic demand, the fight against inflation, and, of course, the suppression of real wages. In Marxist economics, wages are explained within the framework of the relationship between classes over the category of surplus value (rate of exploitation). In neoliberalism, the reduction of variable capital (V) and the increase of surplus value (S) and hence the rate of surplus-value (S / V) are fundamental and determining phenomena. But the strategy of the bourgeoisie is never based solely on increasing the rate of surplus value. Steadily strengthening the rate of profit of capital is the main goal of the bourgeoisie. The bourgeoisie aims the surplus-value which it obtains in proportion to the capital it invests (C + V) (Karahanoğulları, 2019).

Besides, Harvey analyses the fundamental dynamics of capital accumulation within the scope of "Spatio-temporal fix". Here "spatio" is the "place" where capitalist accumulation is realized. According to Harvey, trade in goods and services always requires location changes, which directly prepares the ground for national and spatial division of labor. This need for spatio corresponds to the need for the geographical expansion of capitalist activity. Within this spatial structure, there is a competitive drive on the one hand, and the motivation to reach places where costs are lower or profit rates are higher on the other hand (Harvey, 2004).

In this regard, it seems that neoliberalism is a global political and economic project. In this frame, every capitalist state has a division of labor according to global order,

and thereupon the neoliberal capitalist state has been dramatically improving structural and legal policies to soar its domination.

2.2.3. The Political Context of Neoliberalism

According to Harvey, neoliberalism is the re-organization of capitalism in the international order, and thereupon is the model that regulates its class power. In other words, neoliberalism is the revitalization of class rule (Harvey, 2007). Therefore, neoliberalism is not only an economic project but also a social and political hegemony for that this economic project reaches profit-maximization.

In Gambetti's opinion, a class re-organization must be required to prevent the adoption of socialism by the countries that have gained their independence by struggling against colonizers. It is imperative to act for a new restoration before the problem gets really more serious (Gambetti, 2009). Hence, neoliberalism is an international political economy paradigm that dominates the world through nation-states with eliminating rivals.

Historically, liberalism is the political spurt that is based on bringing the states shaped central and bureaucratic in more humanism than they used to. Thus, there is no denying that it will increase workers' rights, social and economic rights, child and woman rights, and even demand for socialism. In other words, it refers that socialism, feminism, etc., were born in a liberal frame. However, they pose a threat to private ownership, thereupon, the process of capital accumulation. Therefore, conservatism which has been legitimizing the fact that power actively belongs to the state has politically came to liberalism's rescue (Gambetti, 2009). In other words, conservatism has been a political instrument that allows inner contradictions

of liberalism to continue in the process of capital accumulation in order to destroy the increasing demand for rights.

Similarly, Özkazanç emphasizes that liberalism has the different two actors of 'society' and 'market'. Thus, political will enables these actors to run their own autonomous rules. However, if the autonomy of society in neoliberalism would have a detrimental influence on market conditions, political will must be applying pressure to make the society accept the market conditions (Özkazanç, 2005).

David Harvey mentions in his study, namely "The New Imperialism: Accumulation by Dispossession", that the *coup d'état* in Chile in 1973 overthrowing the socialist government, and after that, coups made in Turkey and Argentina are a laboratory of neoliberalism. Besides, even though it does not need a coup, political pressure has occurred in modern western countries, such as the UK and the USA. To illustrate, the pressure has particularly occurred to decrease the power of unions (Harvey, 2004). In the light of that argument, it seems that neoliberalism has been globally built across the earth.

In this regard, Neoliberalism, too, politically needed the same instrument, seen as political pressure according to critical approach. In fact, it needed more than it used to. Since the emergence and implementation of neoliberalism did come together with the pressure regime, it should also be grateful to the political pressure regimes of the states for their own solid and outstanding performance. Therefore, it is no coincidence that conservative governments completely implement neoliberal economic policies.

2.2.4. Turkey's Integration into Neoliberal Global Economy

Turkey's transition to a multi-party system before the 1946 general elections did have not only political but also economic consequences. Afterwards, the protectionist economy and inward-oriented industrialization model were slightly slackened. This is because Turkey had decided to ally with the capitalist West in the bipolar world order after World War II. Mainly in the process of the government of the Democratic Party, more liberal foreign trade policies were adopted via financial aid packages such as the Marshall plan. However, this free trade regime had led to an increased foreign trade deficit, and thereupon, the economy had been shrinking. At this point, IMF had been suggesting that integration into the global economy, in terms of free foreign trade, ought to be pursued. However, the Democratic Party governments did prefer to pursue the market and price controls, such as re-imposing the Turkish National Security Law from 1940, instead of deflationary precautions and stabilization policy based upon liberalization in foreign trade, due to their populist policies. Nevertheless, in 1958, the government had to devalue, because of the fact that dollar-dominated imports had been extremely declining. Thus, western countries, including the USA, had accepted the external debt rescheduling, which the amount of debt is 600 million dollars, and moreover, they had provided a new loan which amount is 359 million dollars (Boratav, 1988).

Furthermore, after the 1960 coup de tat in Turkey that did overthrow the Democratic Party, the governments including the last two years of the Democratic Party, had mainly pursued deflationary policies. In this stabilization policy process which is aimed at structural adjustment, Turkey has first-time used the dominant lending instrument of the IMF, whose name is Stand-by Arrangement, in 1961 and has been continuing to use it in the following years (Yavuz, 2009).

In addition to the excessive rise in petrol price, even if stagnation in the world economy has a harmful effect on the Turkish economy, Turkey abruptly did not face the crisis. The reason why is the inflow of foreign currency of workers who lived and worked in European countries. That led to postponing the crisis. However, the European economy based on petrol that had been facing downsides gave rise to a decline in the inflow of foreign currency and decreased trade with Europe, which includes vast quantitative Turkish foreign trade. Thus, Turkey had to pay the costs of its oil imports in approximately half of its export revenues (Oran, 2011).

Boratav, similarly, mentioned that the inward-oriented, foreign-dependent, import-substitution and populist economic model had been delaying the crisis. However, after the decrease of inflow of foreign currency, in particular, Turkey faced a severe economic crisis in 1977. The international capital environment had been dictating the deal with IMF in order to provide new loans. The governments running Turkey had been trying to withstand that kind of program that burdens the working class because of populist concerns. However, on the one hand, the governments had been partially making concessions. On the other hand, they had been pursuing economic control policy (Boratav, 1988). Thus, the external debt ratios of Turkey had been dramatically expanding until 1980. That situation did bring about the emergence of January 24 Decisions in 1980.

January 24 decisions in an excellent agreement with the neoliberal global economy led to much-debated structural changes in terms of economic, political, and social influences such as frequently recurring devaluations, raising the sale price of basic consumer goods, tight monetary policy, limited public spending except the infrastructure, increasing interest rates, limiting wages, changing exchange rates, etc. These decisions were significant decisions that the economy will be governed by market rules. They have characteristics of structural adjustment in institutional, social, and political areas and are the multifaceted programs that meet the demands

of international capitalism that has become increasingly global since the 1970s. The founding father of January 24 Decisions is also Turgut Özal, who did work in the World Bank in the past and was secretary-general of the State Planning Organisation. September 12 Coup in Turkey paved the way for that January 24 Decisions to be implemented without any exceptions to prevent any expanded opposition. After military government, economic liberalization and the effort that had been integrating into neoliberal globalization had gone on during civil governments that Turgut Özal did lead in the 1980s (Oran, 2011).

The fundamental elements of January 24 Decisions are 1) Foreign Exchange Policy: depends on rate arrangements according to perpetual devaluations and shows an upward trend, in time, in the degree of liberalization. 2) Import Regime**:** liberalization dominates thanks to taking import quotas off. 3) Export Regime: is given priority nationally as a virtue of affordable credit, and expensive currency concessions such as tax rebates. 4) The elimination of heavy industry and public investments including basic goods. 5) Privatization of State Economic Entreprises. 6) The abolish subsidies regarding price controls. 7) The restraining income policies containing wages and salaries. 8) The domestic demand is reduced (Boratav, 1988).

In this economic framework, Boratav called it 'the counterattack of capital' (Boratav,1988). Furthermore, the economic policies are based upon control and regulation against the working class, on the one hand, the sake of capital on the other hand.

In parallel to these frameworks and arguments, Kafaoğlu highlights that as a result of trade policy after the 24th of January 1980 based on external purchase, the proportion of exportation had been declining at the rate of %40. It means that, as Kafaoğlu's statement, " a good that was bought by 100 bales cotton before, now,

has to be bought by 240 bales cotton. " Besides, it had resulted in that Turkish liras depreciated against dollars (Kafaoğlu, 1984).

We can see that, for decision-makers, an export-centered economy overweighed, the economic policy had been sharply starting to be disadvantageous to workers. Moreover, the fact that Turkish liras depreciate in value against rate shows the subsidiary place where Turkey Capital Regime is in the neoliberal global division of labor.

Economic reflection and decisions in the Turkish economy that has been built in the1980s according to the neoliberal global economy have been continuing, too, until today. The neoliberal program has been able to be thoroughly implemented in the governments of the Justice and Development Party in the 2000s in particular, just like in the conservative governments in the western world. This study will focus on the JDP era and its reflection on healthcare as an area becoming marketable.

There is barely any social sphere not seen as a commodity in the neoliberal era. Therefore, the main purpose is to be transformed society into individuals and communities to open investment in any area. In other words, the tie consisting of citizenship was replaced by the community in the neoliberal era. Thus, institutions i.e. unions, trade associations, etc. that did not comply with neoliberal economic instructions will have socially been weakening. In addition to it, state force, too, will have been catering for the establishment of neoliberal economic order. These are political instruments of neoliberalism. It means that the excellent and articulate cooperation between neoliberalism and conservatism did supersede the implied partnership between liberalism and conservatism. Thus, the Turkish - Islamic - Market synthesis which was gradually constructed in the 1980s, has been drastically penetrating society over the last two decades in Turkey thanks to Justice and Development Party (Özkazanç, 2005).

It was mentioned that neoliberalism is not only an economic program through structural reforms. According to Gambetti, in neoliberal order, social policy i.e. health and social security have been replaced by services that are provided by foundations and associations such as zakah and alms. This is because, the main public services such as health, education, etc. have been privatizing. In this process, the fraternal organizations have been precipitously given a floor to expand and likewise, local governments have been gained significance (Gambetti, 2009). In other words, the state has been withdrawing from its fundamental duties, thereupon the market has been playing a critical role over the society.

The milestones of the neoliberal journey of Turkey are, at the same time, some laws that have been enacted since the 1980s. During Turgut Ozal's governments, the "Foreign Capital Framework Decision"aimed at the entry of foreign capital to the country, and were in "co-operation"with foreign capital were implemented. However, mainly, precautions that generously invite foreign capital investments were provided by Justice and Development Party (JDP) with "Foreign Direct Investment Law". These regulations have been enabled foreign capital to invest in previously thoroughly uncommercialized areas such as the healthcare service.

2.3. HEALTHCARE

As emphasized earlier, Health has been, in an atmosphere in which neoliberal economic policy has been privatizing everything in general, a revenue-earning commodity. Besides, due to the fact that we are exposed to privatization and neoliberal language a lot, even critical studies have been vividly calling 'Health Sector'. This part of the research will explain the role of the state and the relationship between health and political economy and defend health as a right.

2.3.1. The Definition of Health

Health is a concept in which not only the individual but also the state has an elbow room related to guaranteeing the right to life. Moreover, today's content of the concept includes not only the individual's well-being as a physical being, but also his / her spiritual and social well-being. According to the Constitution of World Health Organization (WHO) which was signed by representatives of 61 states on 22 June 1946 and, came into force on 7 April 1948, *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."* (WHO, 1948) This broader definition of health has been underlining that states not only adopt an epidemiological approach to therapeutic services, but also that they have to have a comprehensive approach to all things social, political and economic regarding the health and healthcare. The content of making living a socially and economically productive life has been added into the definition of WHO (Kesgin & Topuzoğlu, 2006).

However, there are some criticizes for the definition of health concerning social well-being. There is no general consensus that is built regarding what social well-being specifically is. The content and scope of the definition are questionable for some pro-opinion including the free market. Notwithstanding without consensus, Akalın is revealing the general scope and content of the social well-being concept. According to him, even if there is no consensus on what social well-being is, reaching food, clothes, housing, comprehensive healthcare, baby and elderly care services, higher education, and having job security, income above poverty consists of objective criteria of social well-being. In addition to these, not being a subject of discrimination ethnically and socially and not being exposed to discrimination depending on sexual orientation and gender are main components of social well-being as well (Akalın, 2015).

Moreover, health has been, defined as a fundamental human right in The Universal Declaration of Human Rights in 1948 as well. According to article 25 in the declaration, everybody has to have the right to humanely living standards such as access to food, housing, healthcare services, social and economic rights in the case of elderly, disability, and illness. Besides, it mentions that all mothers and children must have free access to providers (Human Rights, 1948).

One of the other significant developments illustrating health as a right is the International Conference on Primary Health Care, Alma-Ata, USSR, in September 1978. The importance of the conference is that it depicts health as a right, such as defined in The Constitution of the World Health Organization, however, this time, that it did strongly point to health as a right. According to Alma-Ata Declaration that assumed a holistic and comprehensive view concerning health and healthcare services, the state ought to have responsibility for the people's health (WHO, 1978).

Within this context, the fact that health had been becoming a profit area had been anything sight unseen until the emergence of neoliberalism. On the contrary, international meetings and international declarations had been based upon that health is an invaluable, untransferable, and unique part of human rights, and thusly, the state role had been underlining on what the state provides its people with healthcare services. The dominant view on health was rights-based. More clearly, it was not an area open to investment yet.

However, after the neoliberal economic policies started to dominate and liberalize all living areas, even if these statements remain on the paper, health has been a lucrative investment area for the capital. In other words, the rights-based view regarding health has been abandoned to a market-oriented approach.

The other side of the coin is the widening and becoming greater gap between rich and poor in the neoliberal era. In addition, due to commodification of health, inequalities concerning access to the health and benefit from healthcare service is vividly seen as well. These are lately considered and criticized by international institutions, notably within the context of health. The solution recommendation is also to underline the rights-based view and the state role again. According to the final report of Commission on Social Determinants of Health, health ought not to be a commodity for trade. It is a subject of human rights, besides, it is under public responsibility. It cannot be left to the market initiative. It has to be made available equally and universally without any payment. This is because, the commission depicts that health is a fundamental human and social need (World Health Organization, 2008).

Finally, even if the intensity of the concept of the right to health has been declining for the sake of the market in the neoliberal global order, it has been questioning recently, because of the fact that the neoliberal economy exacerbating inequalities.

Similarly, in this process, this broader approach has reflected on Turkish law as well and health did enshrine as a right in the Turkish Constitutions. Constitution 1961 has contained strong positive liabilities in terms of the state within the context of health (Constitution 1961, Article 49).

The liabilities of the state on health have reduced a little bit in Constitution 1982, and thereupon, there is no emphasis concerning strong state role. The state's role is now regulatory. Even if the content of the health regarding the right had been protected on the paper, it seems that there is the underline of cooperation with the private sector in harmony with the neoliberal economy which started globally to be implemented at that time. Like the study will analyse in the following, private activities on health will hugely expand from the beginning of the 2000s onwards

thanks to economic decisions of the governments and laws that lead to increase private activity (Constitution 1982, Article 56).

2.3.2. Social Security

Social security means the protection of the society provided by public measure in the context of economic and social obstacles as a result of illness, unemployment, job accidents, death, birth, elderly, etc. In other words, the reason why it emerged is depending on the decrease in income and the go up of the expenditure. Therefore, social security contains social protection in the meaning of social risk leading to be decreased income. This is because these situations lead to economic insecurity including labor loss. In this regard, social security policies aimed at eradicating the physiologic, economic, and social influences of these risks over the people. Most of the risks contemporary social policies purpose to mitigate are generally related to health such as general practice care, services regarding birth, basic medicines (Güvercin, Sosyal Güvenlik Kavramı ve Türkiye'de Sosyal Güvenliği Tarihçesi, 2004).

It can be propounded that social security has been needed during the history of human beings. There is no doubt that this would be primitive social security rather than institutionalized social security within these days' content. The intratribal and intrafamilial solidarity and help in primitive society can be considered as such social security. The livelihood of everyone working and not working in these communities is provided within the bounds of possibilities of each tribe and family, thusly the requirements of disadvantageous groups i.e. child, elder, disabled had tried to be provided in this way. The change in the relations of production and the social division of labor is the main point that social security is starting to stray from the family. Nevertheless, historically, the start of industrialization containing

capitalist mode of production, capital accumulation, the market, etc. had a profound effect on society.

The initial implementations of social security can be found as laws including poorness, labor, and settlement in Europe, notably in the era that the mode of capitalist production did start to become influential in the 19th century. Therefore, it is strongly regarding a capitalist mode of production. In the capitalist mode of production, the main goal is to maximize the level of production quantitatively, through the division of labor and technological innovation, which brings together the means of production. In this case, the change on the labor front in terms of capitalist logic was the transformation of labor from the traditional part-time or seasonal form to the shift or full-time form required by industry (Akyüz, 2008). As mentioned above, the risks including job accidents, loss of revenue, the increase in expenditure, illness (especially occupational diseases) have arisen from that change in the relationships of production. As a result of it, social demands for decent living had soared. Therefore, the capitalist system, to be sustainable and protect its class benefit and power, did bring up the issue regarding social security and social policies. Besides, the development of social security systems can be seen as two -stages historically: Classical Era -with the starting to be accepted social insurances whose founding father is Bismarck in Germany- and the era after World War I (Güvercin, 2004).

In other words, due to the increase of demands for a decent life, Bismarck, to integrate the working class into the capitalist system and protect the system, did form social security system in Germany, whose name is Bismarck Model. This is because charity funds which were partially institutionalized even if solidarity strayed from the family in the industrialization era could not afford the crises. Besides, socialist movements had been going up supported by the working class. Bismarck Model firstly has old-age insurance and disability insurance for

disadvantaged groups. All workers within the scope of the law are subject to compulsory social insurance law. In addition, the premiums have been distributed between workers and employers according to income. Even if the other European countries did criticize it at the beginning, however, they had been starting to adopt this system in time. Nevertheless, there had not been using the concept 'Social Security' in this era. The Soviet Union which established in October 1917 Revolution did start to implement comprehensive and centralistic social security systems, and the Social Security concept is used first time in the enactment on October 18th, 1918 in the Soviet Union. All duties regarding the elderly, working, and illness did belong to the state in conjunction with constitutional changes in 1936. Besides, all citizens had the right to free access to health (Akkaya, 2000).

In this framework, politically and economically, healthcare services have been added to social policies for both reproductions of labor and the protection of the system. Therefore, healthcare services are not independent of the economic policy of capitalism. As mentioned before, different economic approaches and developments, too, did affect healthcare systems, due to the roles being attributed to the state and the market. While, according to Keynesian economic policies, the state had to address the needs related to health - which means that the market rules do not have to be valid in the areas such as health, education, hosing-; neoliberal economic order has been defending that the private activity has to drastically expand on health like every sphere.

Furthermore, health is not only a service that must be provided but also an employment area. It means that it refers to the production area as well. Health as a service protects impairment of the public health, thusly, it also protects productiveness of labor to provide re-worked. Health as the market has the buyer and seller roles. Therefore, the basic assumptions of economic policies incorporate healthcare (Belek, 2016).

Within this economic and historical context, there are mainly three healthcare systems that emerged in Europe and did spread the world. 1) Bismarck Model - Social Health Insurance 2) National Healthcare Services System - Beveridge Model 3) Semashko - Communist National Health System (Groenewegen, 2007). The differences are basically that Bismarck Model is based on premium, Beveridge depends on taxes and Semashko is fully coming from the state budget.

2.4. CONCLUSION

There had been realizing social, political and economic profound transformations in company with industrialization and thereupon the change in production relationships and the improvement of mass- production in the 18th and 19th centuries across the earth. Thus, the new state regime emerged and the new economic order dominated. These did have a significant influence on society such as the emergence of different classes. In this process, the dominant economic model was shaped by liberal philosophical theory and liberal economic approach. This has mainly based on fact that the modern state has a class core containing class power. In other words, the society mainly fragmented into two classes - workers and the bourgeoisie- and the state started to act upon one class's benefit.

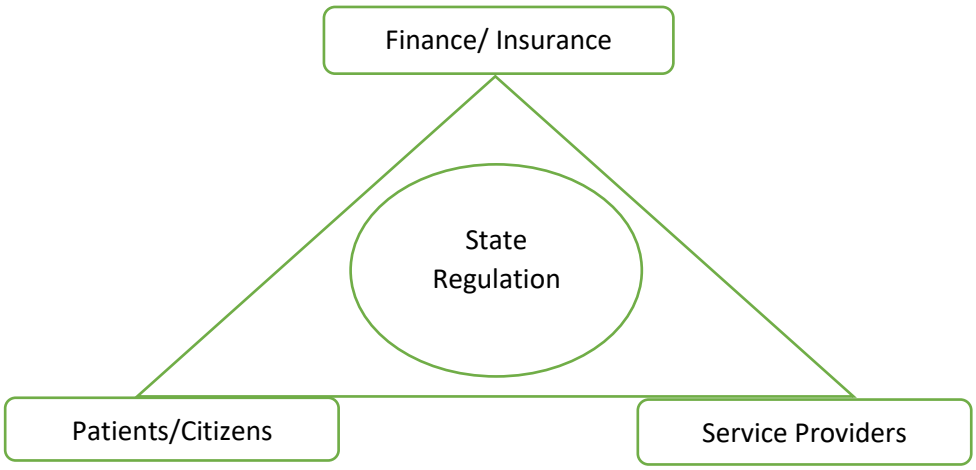
These radical changes were characterized depending on the free market rules consisting of the desire its profit-maximization and capital accumulation. The main purpose of the liberal economy is commodification and marketization of everything. Therefore, class society structure did lead to broader inequalities, and thusly, demand for social and economic rights. Besides, this economic order in the class society structure did bring about economic crises in the history of liberalism. Therefore, for the continuity of the system, some economic approaches had been dominating in the process of the crises. The Keynesian economic model and

neoliberal economic model are alternative products of these processes inside capitalism.

The liberal free-market economy policy, in addition to its structural economic crises, has been facing downsides such as demand-driven movements including social and economic rights. The system, according to the dominant economic model in that period, did create solutions. While social and economic rights had been expanding in the Keynesian economic model process, they have been decreasing in the neoliberal economic order.

Within this frame, health is one of the significant components of social and economic rights. Therefore, health is defined and determined by the dominant economic model. Neoliberal economic order purposing more commodification and marketization of whole living sphere has been commercializing health since the 1980s when it emerged until today. Even if healthcare systems developed in Keynesian social policy eras such as Beveridge and Bismarck Models have been protecting their existence, private activity has been showing an upward trend in these systems compatible with neoliberal economic policy. In other words, the state's role in health and right-based approach have been drastically weakening.

Figure 1. The State Regulation



Source: Groenewegen, Peter P., Doğu Avrupa'da Sağlık Reformu, 2005

The decline of the state's role is vividly shown in the table of Groenewegen. According to Groenewegen, in order to understand health systems, it has to look at the 'health actors triangle'. Three corners of the triangle include Finance, Users who benefit from healthcare services, and Service Providers. The picture is mainly drawn by the fact that the citizens pay taxes or insurance premiums, they get service, and service providers receive a salary. State Regulation is basically positioned in almost center of these. It means that the main structure of health systems has consisted of relationships among Service Providers, institutions of Insurance or Finance, and Patients. These relationships have also been regulating by the state (Groenewegen, 2007). State regulation has been the most determinant factor in this framework. Service Providers have been now the Private Sector and The Finance has been managed for the sake of Private Sector's profit. To sum up, where the position of the state regulation has been staying is, specifically, closer to the market economy these days than it is used to.

CHAPTER 3: THE HISTORICAL TRANSFORMATION JOURNEY OF SOCIAL SECURITY AND HEALTH IN TURKEY

3.1. THE HISTORY OF SOCIAL POLICY IN TURKEY

3.1.1. The Late Ottoman Era

The formation of social security systems in Europe was only possible with the realization of the industrial revolution and the making of the working class, as had been mentioned hitherto. On the other hand, the Ottoman Empire did not become industrialized, and therefore, a working-class that would demand rights for social protection did not emerge. With the family structure continuing to function as a protective unit, the limited and dispersed social protection measures in the Ottoman Empire could not turn into the institutionalized social security system. Besides, some services, i.e. patient care and elderly care, were also provided by any member of the family belonging to extended family structure depending on agriculture. In other words, the family as an informal solidarity form did shoulder the lion's share of the need for care. On the one hand, that fact was evaluated as non-institutionalized social security implementation; however, on the other hand, it did prevent the making of social security and social policies that the state must provide (Akkaya, 2000).

Moreover, charity organizations depending on religious traditions had a critical role as well. To illustrate, zakah, donations, and a special form of Islamic alms-charity were the main instruments to protect poorer people. Besides, associations such as The Red Crescent and "*Darülaceze* Institution" became more organized and significant in the last era of the empire within the context of social aids (Güvercin, 2004).

The non-agriculture areas were also based on manual work. In the case of any risk, like illness or accident, the crafts had faced the loss of revenue. Therefore, in analogy to Europe, the guilds were established to prevent social risk. The solidarity of guilds was called “safe deposit boxes in the Ottoman Empire”(teavün). The sources of funds were subscription fees provided by masters according to their ability to pay. These had been supplying aid, including health (Akkaya, 2000).

Although the period by which Health facilities started to be built is the 19th century, another feature of the late Ottoman era related to social security is that social security did not contain health services. Social Security was already regarded as a very narrow approach of charities. General healthcare services, too, were coming from a healing house which is established by padishah and was based on alternative medicine. The administrative and organizational structure of the health services was military-driven in conjunction with the fact the general administrative organization was coming from the military origin. The first official organization inspired by France is the “International Corpsman Assembly”*(Beynelmilel Sıhhiye Meclisi*) established in 1839. The second institution is *“Cemiyeti Tıbbiyeyi Mülkiye*” established in 1878. The second institution's duties and authorities expanded in the following years. Nonetheless, only military and administrative personnel were provided with health services. Briefly, even if it was limited, there was an effort for healthcare provision. However, the overwhelming majority of the population could receive healing service support only provided by charity organizations, which were based on alternative medicine and established in some particular and limited areas, due to the fact that healthcare was not regarded as a fundamental duty of the empire (Akdur, 1980).

3.1.2. Early Republican Era

Ottoman Empire did not legate The Republic of Turkey even a partial institutionalized social security system as mentioned hitherto, except provident funds that were established by particular occupational groups. Healthcare services as an institutionalized service were also quite limited and barely existed.

Despite the fact that there were no direct regulations on social security in the early years of the Republic, some indirect regulations were made with laws, such as the Code of Obligations in 1926 and the Public Health Law in Turkey (*Umumi Hıfzısıhha Kanunu*) in 1930. During this period, laws had been enacted, for example loaw on social insurance, which had been stipulating the establishment of retirement and solidarity funds with a narrow scope in terms of risks. One of the most significant laws is the Military and Civil Retirement Law in 1930 (Askeri ve Mülki Tekaüt Kanunu); and shortly after, some funds were established by civil servants such as the "Provincial Special Administrations Retirement Funds in 1933" (the Istanbul Local Administration Pension Fund and the Ankara Municipality Officers Pension Fund) and "the State Railways and Ports Administration's Officers and Servant Retirement Fund in 1934". Workers have established similar social support funds as well. Most importantly is the "Amele Birliği İhtiyat ve Teavün Sandığı" established by the miners in Zonguldak and Ereğli regions in 1923. Besides, "Samsun Tütün İşçileri Teavün Sandığı" established by tobacco workers in Samsun and "Yardım ve Teavün Sandığı"established by the electricity factory workers in Istanbul are examples of such organizations (Güvercin, 2004).

From the date of foundation of the Republic until 1936, it is seen that a comprehensive regulation on social security was not made. However, the retirement funds, which were established during the Ottoman Empire period to provide social

security for public employees against the risks of old age, invalidity and death, were reformulated with the “Military and Civil Development Law” dated 3.6.1930, numbered 1683 (Şenocak, 2010). Thus, civil servants were provided with new rights in terms of social security as mentioned above. Considering that the overwhelming majority of the dependent workers were working in the public sector at that time in the Republic of Turkey, a country with low levels of industrialization, the positive impact of every decision made was enourmous in terms of social security.

Within the framework of the “Labor Law” numbered 3008 and enacted in 1936, the establishment of social insurances and basic principles regarding social insurances have been stipulated in Turkey. Undoubtedly, we can say that the term “social security”was brought into our legislation for the first time with this law. This is because some social and economic rights in this law protected workers and regulated the relations between the business world and the labor market. For instance, according to the law, weekly working hours are limited to 48 hours. Even zooming into today’s hustle and bustle world and even looking at other countries' working hours beyond those who have industrialized early, the law reveals a very reasonable level in working hours for the workers in Turkey at that time. In addition, working rights and paid leaves are introduced, like maternity leave, and thereupon women's working hours were arranged in the law. These are, by and large, substantial breakthroughs for labor rights in Turkey at that time.

The 7th section of the law called Social Aids is arranged that the state role is a must in the case of the work accident, elderliness, illness, death, and motherhood. The social security in these cases are organized by the state. Therefore, a government agency whose name is Worker's Insurance Administration will be established in a year after this law enacted. In addition to these developments, the law did, conflictingly, ban the right to bargain collectively, strike, and lockout.

However, a real social security system could not be established during the period from the proclamation of the Republic until 1945. On the contrary, the political environment was severely under pressure due to the think of communism danger in this period. The right to bargain collectively and to strike was suspended. Although the prohibition to the right to bargain collectively and to strike is lifted, the unions had been enclosing. This right was not being regarded as a part of labor relations (Buğra: 2008). The first law on social insurance branches is the "Law on Work Accidents, Occupational Diseases and Maternity Insurance"dated 27.6.1945 numbered 4772. With the enactment of this Law in 1945, occupational accidents, occupational diseases and maternity insurance started to be implemented (Şenocak:2010). Besides, it is the first step that health also started to be subject of the social security system in Turkey.

In addition to these legislative developments regarding the labor area, retirement funds concerning civil servants in existence at that time did centralize into one institution in civil servant front whose name is "Institution of Retirement Fund of Civil Servants", thanks to the "Law of Retirement Fund of Civil Servants" numbered 5434 in 1949 (Güvercin, 2004).

Nonetheless, notably, during the 1950s under the severe anti-communism political atmosphere called McCarthyism working, the ban of the right to bargain collectively and to strike had been continuing. Besides, the number of workers in the registered economy was less than peasants. Therefore, both Republican People's Party Governments and Democrat Party Governments did pursue peasantry policies. However, in the era between 1950 and 1960 migration from rural to urban had been starting. However, informal employment was more than registered as well. Nonetheless, those who did come to work in urban areas did not rupture the relations in rural, due to the fact that the rest of the family members did live in rural and did protect their land ownership existing. In other words, their living

arrangements and income strategies did vary between rural areas and urban areas. It, at the same time, led to the lack of a formal social security umbrella. Therefore, working under bad conditions, working informally, and not having a variety of rights regarding labor relations was not paid attention to by politicians as well in the era between 1950 and 1960 (Buğra, 2008).

3.1.3. The Era Between Two Coups: From 1960 to 1980

The 1961 Constitution also strongly underlines that social security is an active state duty. It mentioned that every citizen has to be entitled to social security. The state had to provide the establishment of social insurance organizations (Constitution of The Republic of Turkey, 1961). This article has similarities with the Universal Declaration of Human Rights, article 22. We can also see that this article in 1961 Constitution is a product of the developments in the globe and interaction into it. Article 22 in Universal Declaration of Human Rights underlines that everyone in a society must have the right to social security and the access to it must be free.

In the following years, several legal arrangements were made in the field of social security, in line with the principles stipulated by the Constitution and the objectives regarding the development plans. The Turkish Social Security System has twofold content. The first one is developed in line with an understanding based on non-premium regimes and social assistance and social services. The second one is consisting of social insurances based on the premium regime (Şenocak:2010). The first reform also in terms of the premium regime was realized with the "Law of Social Insurance" numbered 506, which was adopted on 17.7.1964 and entered into force on 1.3.1965, incorporated the social insurance branches that were established until that day. In other words, social insurance based on the premium entered the Turkish social security system, and afterward, the rights concerning healthcare, retirement, and so on did centralize into one institution in labor front whose name

is Social Security Institution, thanks to “Law of Social İnsurance”. In addition, thanks to the Law of Tradesmen and Craftsmen and Other Self-Employed Social Insurance Institution (Bağ-Kur) numbered 1479, which was adopted in 1971 and entered into force in 1972, self-employed workers were also included in the social security system.

3.1.4. The 1980s

In 1983, dependent workers in the agricultural sector were included in the Social Insurance Institution (SSK) with the Agricultural Workers Social Insurance Law No. 2925. Thanks to the Social Insurance Law No. 2926 on Self-Employed and Accounted Employees in the Agriculture Sector, self-employed workers in the agricultural sector have been included in the scope of Bağ-Kur. In other words, there is no fully separate insurance system for the agricultural sector that is regulated (Gökbayrak: 2010).

The 1982 Constitution included detailed provisions on social security. In the third section under the heading “Social and Economic Rights and Duties”, the right to social security is regulated. In Article 60, it is stated that social security is a right for everyone and the state will take the necessary measures to fulfill the requirements of this right. According to the regulation in the 61st article, it is stated that it is a duty for the state to provide the social security of the disabled and veterans, the elderly, and children in need of protection, who need special protection in terms of social security. As seen, compared to the 1961 Constitution, the duty of the state regarding social policy was shrinking within the scope of the people in need. In other words, we can see the effect of neoliberal global economy policy over Turkey concerning social security and the rights.

3.1.5. From the 1990s to These Days: In The Shade of the Privatization

In the 1990s, the Turkish social security regime included 3 social insurance institutions, called the Social Insurance Institution, Emekli Sandiği, BAĞ-KUR. In addition to all, the "Green Card Law" numbered 3816 also enacted in 1992 allowed citizens who do not have any social security to receive free healthcare from public institutions. So that, the system consisted of institutions fragmented according to employment conditions. This model, similar to the examples in Southern Europe, combines Bismarcian corporatism with a traditional family-based structure (Keyder, 2007). Bismakrist corporatism does not involve providing retirement and health care service to all citizens equally. In addition, all social programs that are not based on citizenship are problematic in terms of inclusiveness. For this reason, those who are excluded from the programs are in need of communities or charitable institutions, just as in the period when there were no institutionalized social security mechanisms. Considering that there are a large number of people in informal employment in Turkey, their access to health services and retirement has also been very limited.

Due to the employment-based social insurance system and its inequalities, the structural problems of the labor markets, increasing unemployment, inflation, informal economy, narrowing of the employment opportunities, and the economic crises experienced in the 1990s, decision-makers came up with the idea based on restructuring the social security system. However, they contended that the system has been facing financial crises regarding the deficit, and the deficit has been compensated by the general budget, thusly the budget deficits expand every year. This is the main reason that leads to the crisis in the social insurance system. according to decision-makers (Hamzaoğlu, Nalçacı, & Belek, 2000).

The research conducted by the ILO and financed by the WB loan in 1995 reveals the problems of the current pension system and offers possible reform options. Four main options are discussed in this report. The four main options discussed are the restructured distribution system; the individual savings system (Chile Model); it is a multi-pillar compulsory savings system and a multi-pillar voluntary savings system. The report highlights the separation of health insurance and pension insurance for the short-term reform quest; recommends increasing the retirement age and ensuring harmony between institutions in terms of premiums (Gökbayrak, 2010)

Another report in this period is the report of World Bank named "Averting the Old Age Crisis". WB had offered three pillars system within the context of retirement by explaining in detailed the reasons globally. These are a Mandatory Publicly Managed Pillar, Mandatory Privately Managed Pillar, and Voluntary Pillar. (World Bank, 1994). The compulsory pillars are based upon financial and managerial. The other is supplementary for the people who do want more saving and based on voluntariness. The report amply mentions "pay-as-you-go"and saving function and never includes the concept of the right to retirement, what's more, 'saving' is chosen instead of the right to retirement. The concept of 'saving' will be gaining a reputation in the 2000s in Turkey, as 'Private Pension System'. The report has some policy recommendations which have to pursue: 1) Avoid excessively long retirement periods 2) Don't penalize people who work beyond the normal retirement age. 3) Reduce pension levels on an actuarially fair basis for people who retire early, except for those who are truly disabled 4) Set the same retirement ages for men and women. 5) Eliminate special regimes that grant early retirement for privileged groups 6) Don't use retirement as a remedy for unemployment 7) Raise the retirement age regularly as life expectancy increases (WB, 1994: 323-324)

Another important report is the 1997 report of the Turkish Industry and Business Association (TÜSİAD). This report has very similar recommendations to the World Bank's report, and conceptually “pay-as-you-go” was mentioned a lot. According to the report, the current system will undertake a minimum social protection guarantee as to the first pillar. The second pillar to be established based on compulsory membership will be a system that will operate based on fund management under the name of individual savings funds, only for long-term insurance branches such as invalidity, old age, and death. Health services will be provided through the General Health Insurance and a Health Finance Institution will be established. The contribution of the state to the financing of social security will only be by paying direct premiums to the first pillar programs The second pillar programs, which constitute the center of gravity of the system, will be financed by premiums to be paid by the worker and the employer (TÜSİAD, 1997). The significant effect of these reports is Law, number 4447 in 1999 in Turkey. It did adversely distort the right to retirement.

3.1.5.1.Law No 4447 in 1999: The Threshold of Turkish Social Security System:

The first step of the transformation in the social security system is Law No. 4447, which was adopted in 1999. The law covers regulations regarding short-term and economic parameters of the system in order to close the deficits in the social security system. These regulations aim at increasing the revenues of the system and reducing its expenses. In this context, gradually increasing the retirement age to 58 (women) - 60 (men); increasing earnings based on prime; increasing premiums for some insurance branches and introducing new premiums; changing the calculation method of salaries and incomes connected from the system; In order to prevent unregistered employment, there are regulations such as bringing advance notification of the workplace and those who will be employed by insurance. Law

No. 4447 differentiated between the three existing social security institutions, except for the increase in the retirement age, and excluded public employees from the scope of the aforementioned regulations. In addition, in order to reduce the reaction against the restrictive regulations in terms of the insured, unemployment insurance, which was stated to be unable to be regulated due to the insufficiency of the existing conditions for many years, was arranged simultaneously. It vividly seems that the policies against labor immediately adopt and the rights concerning retirement reduce in the late 1990s. Besides, it has been leading to the increasing burden which workers shouldered at the finance of the social securıty system. According to the DISK report in 2018, the rate of worker contribution to the system had been going up between 2002 and 2015, contrary, the contribution of employers and the state to the social security system had been shrinking at the same period (DİSK/ GENEL İŞ, 2018).

3.1.5.2. Private Pension System

The Private Pension System (PPS) in Turkey entered into force with the Individual Pension Savings and Investment System Law No. 4632, enacted in 2001. In the Law No. 4632, the aim of the Private Pension System is referred to as "as a complement to the public social security system, individuals' savings for retirement are directed to investment, thereby providing an additional income during retirement, increasing their welfare level, increasing employment by creating long-term resources for the economy and contributing to economic development." "Directing savings to investment" and "creating long-term resources for the economy" are the expression of the evaluation of the money saved in the Private Pension System within the financial system. According to the law, it is primarily to increase the capital accumulation by keeping the banking system alive and to ensure the capital transfer from this long-term investment in case of an economic crisis. In times of crisis, especially hot money is needed, and this is nothing new. With the

amendment made in the law in 2013, a state contribution of twenty-five percent of the amount invested in the Private Pension System was brought to those participating in the Private Pension System to encourage saving. With the Law No. 6740 enacted during the state of emergency after the coup attempt in 2016, it has been made compulsory for dependent workers and public officials under the age of 45, gradually coming into effect as of January 1, 2017.

In order to retire in the Private Pension System, it is necessary to stay in the system for 10 years and to reach the age of 56. Up to 25% of the contribution made to the system every month, the state contribution is added to the fund account. However, there are progress payment periods for the state contribution. The rate of benefiting from the state contribution varies according to the period of stay in the system. The Private Pension System is vividly seen as a product of the voluntary savings system that was mentioned in in the World Bank report. However, it has not been compulsory until 2017. It was made mandatory by a Decree-Law during the state of emergency. It clearly shows that the state force enables neoliberal financialization to implement its own desires, as had been mentioning hitherto.

The Private Pension System is not a social security program. The social security system is a predictable system based on the principle of solidarity, including both employer and state contributions and securing a certain income. Therefore, Compulsory Private Pension System cannot be considered as a social insurance program. It does not provide any similar services to either the pension right provided by the Social Insurance Institution (SSI) nor to health and other social security services (DİSK-AR , 2016). Therefore, the ‘Pension’ concept in its name is deception in order to attract people. In other words, The Private Pension System is a financial investment tool brought in favor of finance capital, which has gained weight as a result of neoliberal global policies. It is a financial investment tool in

which you earn money or lose based on fund returns or market movement. Therefore, it is not evaluated as a classical 'retirement'.

3.1.5.3.Two Faces of the Same Coin in The JDP Era: The Neoliberalism and Conservatism

The most significant characteristic of the AKP era in terms of social policies is that it established a social assistance regime through municipalities. The social assistance regime belonging to municipalities is an alternative to a centralistic protectionist state mechanism and thereupon it starts to work by underlining inadequacies in the role of central administrative such as the lack of qualified staff. Therefore, the solution is local administrations and 'social municipalism' has been emerging. The practice of social municipalism is mainly based upon subcontractors and foundations supported by informal and formal ways. Social aids are transformed into charity works provided by traditional foundations or philanthropists. In other words, just like in the light of the neoliberal approach, social assistance is not now the social right protected by the state, it is the service provided by foundations or charities. It is a significant example of the ”Limited State” approach. In the case of social assistance not describing as social rights, clientelism gains importance. It is not an institutionalized structure, partially based on laws and regulation, and therefore it does not contain all citizens. Its scope is limited to 'people in need'. It is centered on informal and traditional relations. Thus, Social Municipalitism including clientelism is built in order to strengthen its power and get political support from the people who are socioeconomically supported by the political power. In other words, there is no direct relationship between the state and the citizens. Therefore, Intermediary Institutions such as communities, Islamic foundations, and Islamic cults play a vital role to destroy the elimination of social rights (Durmaz, 2016).

To that end, some laws towards local administrations were enacted such as Law for Metropolitan Municipalities numbered 5216 in 2004, Law of Municipality numbered 5393 in 2005, and Law of Special Provincial Administration numbered 5302 in 2005.

The other important development in this period is the effort regarding making reform about social insurance. The Law of Social Security Reform and General Health in 2008 is the threshold to jump up to access to health equally. According to law, everybody will be able to access healthcare services and will be annihilated the corporatist healthcare system distributed unequally into social insurance institutions. However, it led to that private activity increases in healthcare. This because the government was aiming at privatizations in healthcare services (Buğra: 2008).

In addition, the law was stipulating a premium-driven security regime and thereupon the reach healthcare services according to it. Considering that the rate of workers in informal employment is very high, it means that there is a huge population that cannot contribute premium and thusly cannot access healthcare services. The law also did not contain article regarding it. In other words, the scope of access to health did actually not expand (Buğra, 2008).

The other adverse effect of the law is related to the right the retirement. According to the law, the retirement age and the number of premium days for retirement are increased. It vividly shows that World Bank's suggestions are paid attention to.

3.2. HEALTH POLICIES IN TURKEY

3.2.1. The Late Ottoman Era

Since the general administrative organization was military-centered during the Ottoman Empire period, the healthcare services provided by the state were organized and implemented mostly for the army. Reisül Etibbalık (physician in chief) is the only official organization that regulates the health affairs of the state and holds the duties and authorities to appoint physicians, surgeons, and other health personnel (Akdur, 1980). In other words, there were no institutionalized healthcare service open to access of everybody, like a social security system. This is because healthcare was not deem as a state duty. The healthcare services that were in existence at that time were desgined for the army and the ruler elite.

With the westernization movement that started in the middle of the 19th century, common health organizations began to be adopted. The Chief Physician institution was abolished in 1849 and the Ministry of Medicine was established in 1850. In 1862, a regulation on medical practices was published. According to the regulation, it was necessary to graduate from one of the medical schools to be able to practice medicine. Besides, according to the regulation of İdare-i Umumiye-i Vilayat, published in 1867, health organization was also included in the general administrative organization (Akdur, 1998).

Nezareti Tıbbiye-i Mülkiye was established in 1870. It is the first central health unit. Thus, the center of the first civil health organization was established (Kasapoğlu, 2016). Finally, the health organization was renewed, taking primarily Italy as a model, and in 1914 the status of the general manager was raised to the level of a ministry in the administrative system.

3.2.2. From The Early Years of the Republic to 1960

The Grand National Assembly (Ankara Government), which fought the National Liberation War, was established on 23 April 1920 in Turkey. The first act of the new assembly was to establish the Ministry of Health whose name was “Sıhhat ve İçtimai Muavenet Vekaleti”. Medical Doctor Adnan Adıvar was the first minister of health. Healthcare was conducted by a different ministry at that time in a couple of countries in the world (Dirican,1970). While the harsh conditions of the War of Independence were felt seriously and the Republic was not formed yet; considering health services as a priority shows the importance that the founding fathers of the republic attach to health.

The assignments of the new ministry of health mainly fought against epidemics such as malaria, pox and trachoma. The regulations and laws enacted in the first 15 years of the Republic were prepared with farsightedness to form the basis of today's health services. For example, the establishment of provincial health directorates in provinces, government physicians in districts, and regulations emphasizing the understanding of preventive medicine, which constitutes the first step rather than treatment, were realized in this period. Especially the “General Health Law” (Umumi Hıfzısıhha Kanunu), which was enacted in 1930, can be seen as a constitution that regulates all health policies. In addition, the acceptance of health as a public service has brought with it the responsibility of training qualified physicians and non-physician health workforce. Dormitories were opened to train inpatient medical students, and the wages of government doctors working in the rural areas of the country, 90% of the population living in villages, were improved in order to encourage preventive health services (Aydın, 2002).

The other significant development in that era is that ‘Numune Hospitals’ were taken into service in cities such as Ankara, Erzurum, Diyarbakır, Sivas and İstanbul.

These hospitals were contained within the organization of the Ministry of Health. On the one hand, Health Board contained within governorship was established; on the other hand, Government Doctorship contained within district governorship was established. In other words, healthcare services were generalized both central and local areas (Akdur, 1998).

The "First Health Plan" was prepared by Minister of Health, Medical Doctor Behçet Uz, in 1946. This plan gathered contemporary preventive and curative services under the same roof as a whole. The state now started to take responsibility for the inpatient treatment services that it had previously left to local governments. For this purpose, health services were organized on the basis of seven geographical regions of the country. A 10-bed "Health Center" was envisaged for every 40 villages. Unfortunately, the targets in this plan could not be fully realized. Due to the construction of a health center or hospital in each district, it turned into an understanding that focuses on treatment. Physicians working in Health Centers, which encourage preventive health services, have become unavailable to provide services due to wage policies that have led to a decrease in the salaries of physicians. Most of the physicians left health centers and started to work independently in order to earn their living. However, the Behçet Uz period is remembered in history as a period in which important steps were taken in the fight against infectious diseases through associations such as Tuberculosis Dispensary and Malaria War (Dirican, 1970).

The most important developments of the 1950s are foundations of the Social Insurance Institution, which became active in 1952, and the Pension Fund, which was established in 1953. Thus, both workers and civil servants started to get health services according to their own social insurance institutions under state guarantee.

Another important development is the incentive of the private sector in the field of health as a result of the government of DP (Democrat Party) which came to power in 1950 and adopted more liberal policies. The inevitable result of this was the uncertainty and even multi-headedness created by both the public and private sectors' activities in the field of health. For example, hospitals which did not affiliate with the Ministry of Health started to be established in this period in order to provide better health services to Social Insurance Institute members. Firstly, the Istanbul SSK hospital was established in 1951.

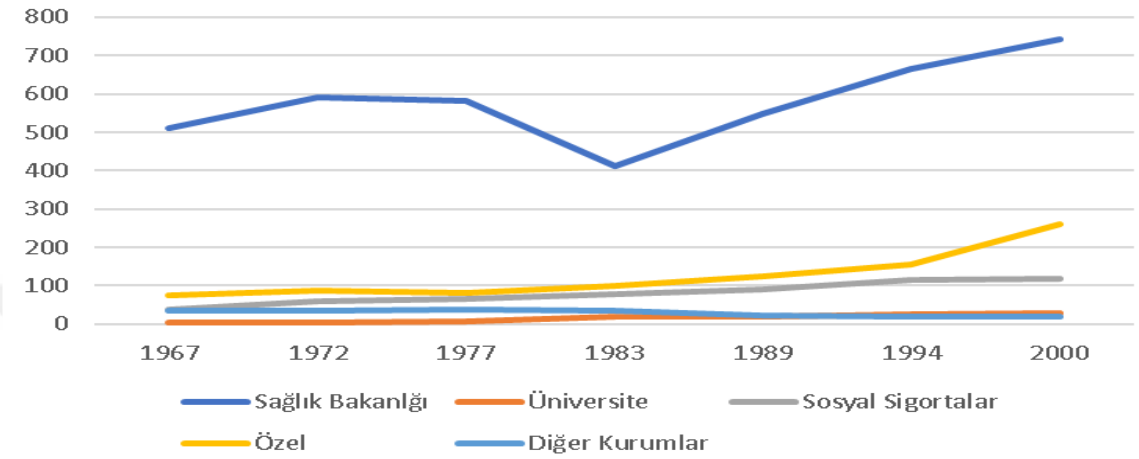
3.2.3. Socialization Project: From 1960 to 1983

One of the most important milestones regarding healthcare policies in Turkey is Law No. 224 on the Socialization of Health Services, which was enacted in 1961. With this law, multi-dimensional service integration was tried to be achieved through health houses, health centers, provincial and district hospitals.

Nusret Fişek, the architect of the socialization project, emphasized essentially the question of how to provide financing for socialized health services. According to Nusret Fişek, the nationalization of services is an understanding that can only be possible in communist countries. The implementation of this system will create problems in countries where individual ownership consciousness had developed, albeit a little. At the same time, it is not possible to provide all services free of charge by the government. In 1963, sector-related targets were set by including health services in the first five-year development planning (TÜSİAD, 2004). The objectives were to develop and disseminate preventive healthcare services, to provide them through the Ministry of Health, to distribute the personnel regularly and in a balanced manner, to implement the revolving fund system in public hospitals, to strengthen the pharmaceutical industry, and to support the opening of private hospitals. Besides, while MoH hospitals are predominantly involved in the

provision of health services, it is observed that the number of private hospitals also increased (Çavmak & Çavmak, 2017).

Figure 2. : The Number of Inpatient Health Institutions Between 1967-2000



Source: Çavmak, Ş., & Çavmak, D., (2017). Türkiye'de Sağlık Hizmetlerinin Tarihsel Gelişimi ve Sağlıkta Dönüşüm Programı

According to Nusret Fişek, the principles of the socialization project are the following ones: Health services will be scheduled; everyone will benefit from healthcare services equally; the health organization will not comply with the administrative division within the province; Community Health Centers (Sağlık Ocakları) are the basis of the health organization; personnel working in the health organization will not be able to perform self-employment; physicians who do not want to give service in the public sector can practice self-employment and the person can apply to any physician, provided that he/she pays the fee; regions consisting of several provinces are established in a health organization; cooperation will be established between the public and the health organization; the administration is allowed to experience by establishing a study area in part of the country; health services of public sector institutions in Turkey will be collected on one hand; predicts the full commitment of healthcare professionals to government service; responsibilities of municipalities (reduced); treatment and preventive

medicine institutions are considered as institutions that complement each other; patients' application methods to health institutions and their opportunities to benefit from free services have been streamlined (Fişek, 1963).

The period of socialization in health started in Muş in 1963 and spread to the whole country in 1983. One-way service understanding in the wide-area was abandoned and a multi-directional service concept was introduced in the narrow area. In order to provide effective socialized health services, of which health centers are an important component, physicians were not allowed to open a private practice. However, this was not always achieved in practice and the system started to wear out.

Although the General Health Insurance law, which was prepared to support the system, was included in the second five-year plan, it could not be enacted. On the other hand, in 1978, physicians working in the public sector were forbidden by law to open private practice for full-time work. Later, the government, which came with the military coup in 1980, made regulations that allowed physicians to open a private practice. All these show “discontinuities”in state policies in the provision of health as a public service.

On the one hand, the 1960 military intervention and the ensuing 1961 Constitution provided significant improvements in terms of social rights and work peace in the country; on the other hand, the 1980 military junta and the 1982 Constitution have resulted in the restriction of rights and freedoms in all areas, particularly the Higher Education Law.

3.2.4. From 1980s to Nowadays

The most important feature of this period is that a policy based on the supply and demand rules of the market for health and social security services started to be preferred. Akdur called this period “Actively Privation Era”. The most important feature of this period is that a policy based on the supply and demand rules of the market for health and social security services started to be preferred. The constitution regulated according to it and what's more, it has been enabling private activity to invest (Akdur, 2006). This is because the state role is now regulatory and healthcare is not now the state's duty.

The definition of “state based on human rights” was changed in the 1982 Constitution and transformed into a “state respecting human rights”; health is ceased to be a state duty. Instead, the articles that the state will supervise and regulate health services were written. Thus, in the 1982 Constitution, the opinion of the private sector in health which started in 1950 and 1970, was officially mentioned. Within the framework of the vision of equality in access to health services, it has been aiming that private health institutions provide services and compete with the public.

According to the legal regulations of the 1980s, the Ministry of Health is the main institution responsible for providing primary and secondary healthcare services. Primary care services are provided by the Ministry through health centers, health houses, mother and child care and family planning center, tuberculosis dispensaries, malaria centers, cancer warfare; secondary and tertiary services are provided by the MoH together with other public institutions, associations, foundations and private persons. In addition, MoH is responsible for determining general policies regarding health services at central level (Kasapoğlu, 2016).

The economic result of the health policies of this period is that the share of the general budget in the financing of hospitals has gradually decreased and the share of health insurances and other resources increased. The means of change in the financing of public hospitals is the revolving fund management model.

Although the first regulations regarding the revolving fund management model in the field of health were made in the 1960s, it started to be implemented in the 1990s and accelerated. While Revolving Fund revenues constituted 13.7% of the Ministry of Health revenues in 1993, this rate increased to 81.4% in 2003. Likewise, while the share of revolving fund revenues was less than one-third (29.1%) compared to the budget of the General Directorate of Treatment Services in 1993, this rate exceeded twice the budget of the General Directorate in 2003 (214.3%) (Pala K. , 2005).

Due to this change in the financing structure, the 'public' content of public hospitals should be questioned. Even public hospitals have been now starting to be managed with business logic. This is a vivid reflection of neoliberal policies on healthcare. In addition, another factor of this transformation in the financing of public hospitals is the proposal of a 'controlled privatization' approach by WHO (Pala K. , 2018). In other words, it clearly seems that there has not been a need for even Keynesian policies in healthcare services since the 1990s.

The World Bank mentions the need for organizational reform in healthcare in its report in 2003. The basic stages in the reform proposals called New Public Management or Marketization are autonomy, corporatization, and privatization (World Bank, 2003). The ideologues of privatization and free-market mostly underline that public hospitals are insufficient and ineffective. According to them, the insufficiency and ineffectiveness result from executive awkwardness. However, the research show that the hospitals belonging to private companies bring about

more cost. Moreover, the reason why the cost occurs is administrative expenses, not executive awkwardness (Soyer, 1995).

The structure of neoliberal health reforms which has been commercializing health and making it a new profit maximization area for capital has dramatically been influencing public hospitals in terms of financing structure and organization since the 1980s. In this process, hospitals have been forced to generate income from extra-budgetary sources. It is inevitable that this obligation will deepen the experiencing inequalities. With the new architecture of the global economy and the suggestions of international organizations, private enterprises in health services have increased in Turkey since the 1990s. Within this process, Health Transformation Programme did emerge in Turkey in 2003. It will be comprehensively examined in the following part.

3.3.CONCLUSION

The Republic of Turkey has been preferring integration into the west-centered capitalist hegemonic system since its emergence. Therefore, the fact that influences and determinates its economic policy has a strong relationship with the dynamics and developments in the capitalist world order. Therefore, social policies and health policies in Turkey stem from capitalist developments. Keynesian political economy's reflection in the 1930s and 1940s is that on the one hand, laws regarding regulating working relations enacted, on the other hand, social security system are adopted without labor movements even if it is a partially institutionalized structure. The determinant characteristic of the period is strong protectionist policies and state hand regulating market just like in the western order.

Even if the era between 1950 and 1960 in terms of the social policies and health policies are not regarded as a state duty and liberalization did increase, populist policies did adopt mostly related to the peasantry. On the other hand, until 1960 some social laws notably regarding social insurance like illness and elderliness enacted. After the 1960 coup adoption of the health system for all and strengthening state role in healthcare services were being regarded as the main duty. Therefore, socialization project had been implementing until 1983, even if it did not expand across the country and did not result in success as much as aimed. Nonetheless, private activity in health is on the table every time. Due to the fact that the socialization project brings socialism to mind, the system is based on the premium containing both worker and employer contribution, although the state role is strong. These are similar in the world. The most important actor of social policy and social security system is the state that is of course the founder and executor of the system at the same time. Almost all countries in the world have adopted this understanding since the years following the Second World War, and the state has become the main actor of the social security system by assuming a central and founding role. In other words, in the period known as the golden years of capitalism, the state is "social"not only in constitutional texts but also de facto.

However, in the 1970s, the golden age of capitalism came to an end, and an alternative solution to Keynesian economic policies was found: neoliberalism. Turkey began to integrate into neoliberal economic policies after the 1980 coup. In the neoliberal conception, the state's social spending and interventionism are associated with wastefulness and authoritarianism. Therefore, neoliberalism's 'actor' preferences shaped in the triangle of individuality, market, and volunteering are at the forefront. For this reason, it is a crystal-clear fact that the social policy regime adopted will be at odds with the "social state" that has been mentioned before.

Therefore, since 1980, notably after the late 1990s, the social and economic rights have been gradually narrowed in the social security regime of Turkey and privatization has been paved the way. At this point, the neoliberal prescriptions of national or international institutions such as the World Bank or the business world have been adopted in the Turkish social security system as well. The prescription is mainly focused on privatization, commodification, and marketization in every area. Besides, contrary to the import substitution industry in the Keynesian era, the finance capital has been building its class power among class fractions. Therefore, neoliberal period is an excessive financialization era at the same time. Within this context, the retirement age is increased, moreover, it is being financialized, i.e. the Private Pension System, and private activity in healthcare is expanded. In addition, the scope of the social security regime has been declining. The best political partner of neoliberalism is social conservatism. Neoliberal prescriptions have been undergoing in Justice and Development Party governments in Turkey. Health Transformation Program is the latest neoliberal practice in Turkey as well. The next chapter focuses on privatization in healthcare and its significant component -City Hospitals.

CHAPTER 4: THE CASE OF CITY HOSPITALS: THE LAST ATTIRE OF THE PRIVATIZATION

The private service in healthcare had been limiting in the private practice of the doctors for long years in Turkey. In other words, commodification, marketization, privatization, and the industrialization of health as a sector had been limited by the state due to the fact that health was regarded as a part of social and economic rights and human rights. Therefore, the state was responsible for the provision of healthcare. Besides, medication was under state control as well.

However, by starting in core capitalist countries, after 1980 -notably with the 1990s - health has been drastically becoming the area of capital accumulation in periphery countries such as Turkey. Therefore, health has opened to investment with the suggestions of WB and IMF. Thus, the hospital chains, the private polyclinics, and the private insurance companies had started to emerge as a huge industry (Sönmez, 2017).

There are some several discussions regarding privatization in the literature. Liberalization is regarded as a competition among different more actors than one. In other words, liberalization is basically defined as market penetration of more than one actor in order to provide service. Thus, the preferential right that consumers decided on anybody among different suppliers is significant for the rationality of the market. On the other hand, privatization is explained as the transfer from the public to the private sector. It means that public entities and public wealth are assigned to the market. However, privatization ought to be approached like two faces of the same coin especially in the area of social services that can be rarely marketed and competitive. This is because advocates of liberalization and competition try different methods in these areas, such as health. In such cases, advocates of liberalization and privatization often seek alternative methods to

achieve similar effects. The healthcare sector stands out because it encompasses a wide variety of processes that imply a shift towards marketization, including the promotion of vendor-recipient relationships and prices, the pricing and individualization of risks, the adoption of preference, and consumer behavior. Besides, the other elements of privatization of health are that business administration methods belonging to the private actors are implemented, the PPP method is increasing, and boosting the number of private capitalists thanks to privatization of public entities. The common point of all these developments is that they contribute to the making of health markets, which predisposes for commodification and commercialization of healthcare services (Herman, 2010).

The privatization in health is essentially realized in two headings. One of them is the production of services, the other is the finance area. The management of the hospital is the best concrete example in the production of services area. The primary healthcare services do not have been able to survive in the struggle with private entities in the last years that capital accumulation and intensification have been increasing. On the other hand, the private insurance business has been becoming a 'finance option' that users have been adopting de facto with the increase in contribution (Belek, 2016).

Policy-makers have been excessively willing to privatization of healthcare due to the fact that bias concerning the benefits of privatization since the beginning of the neoliberal era. Besides, the governments have been directed by international institutions and capitalist actors within the context of the significance of privatization throughout various reports and suggestions. I mention the concept of 'bias' because privatization is a holy concept belonging to the free market and privatization is sacred from the liberal perspective. However, health must be a unique area to the extent that will not be privatized according to me. Besides, both critical studies and mainstream studies that commonly highlight private activities

in health have been using the notion ' Health Sector'. In this chapter, I, too, use the notion 'Health Sector'; but also I mention it pejoratively and negatively.

Furthermore, the assumptions concerning the advantages of privatization are as follows: 1) The private sector is independent of the state bureaucracy, and thereupon, it does not face political and executive congestions. Therefore, it gives rise to boost effectively and efficiently the management of sources. 2) Scarce state resources ought to be liberalized in order to enable poor people to benefit from healthcare to the degree of their power. Thus, private actors will be able to provide services that the limited state services could not reach. 3) The penetration of market actors acting competition in public health services might bring about the increase of quality (Muschell, 1995).

Privatization is separated as active and passive according to Jeff Muschell. Active privatization means that the state implementation enthusiastically and consciously convinces the changes in the roles of public and private responsibilities. Passive privatization means that the private activity develops on its own motion without whatever policy changes. For example, in addition to selling public entities, the contract system which was created by the fragmentation of the institutions that provide service and finance can be accepted as active privatization. Passive privatization also usually emerges in the case of an economic crisis. For instance, in the case of crisis, the state has to pursue tight fiscal policies, and whereupon, the budget of the state sector is strictly audited. It also brings about that healthcare personnel run from the state to the private. This is an example of passive privatization. Besides, one of the consequences of passive privatization is the rise of the informal health sector. As a matter of fact, it makes the balance and follow-up of cost and quality impossible (Muschell, 1995). To illustrate; the rate of the Private Institutions regarding Oral and Dental Health Services in Turkey is more than %50. However, the proportion of the adults who benefit from it only one time

in a year is still less than %50 according to 2015 data even if it had been increasing since 2003 - from %40,4 to %45,2 - (Özyavaş, 2018). That is to say, the 12 years' period is too long, however, the rise of the rate is very low. Besides, it vividly shows that lack of resources in dental and oral health can result in increasing private activity and thereupon every people cannot equally reach access to dental and oral services. The passive privatization is driven like that.

To sum up; although privatization is regarded as the transfer of resources from the public to the private, the concept has been expanding, including the infusion of market relations into the health sector thanks to contract models. In the case of the fact that public ownership has been protecting, contract models allow two ways to privatize. One of them is that the market rules are enforced in public institutions. More clearly, these implementations are to remove subsidies, end the monopoly of the public, increase subcontractors and provide autonomy of the public entities. The second way is the transfer of the management of public institutions whose public ownership is protected. This is a privatization application with contract models within the context of the fact that service, finance, and production are based on fragmentation (Perrot, 2006).

Within this framework, the main goal of privatization is depending on increasing the movement area of the market in the context of health. The pharmaceutical industry and medical technology have already been traditionally under the private sector, as we have been facing until now. In addition to it, the privatization operation has been targeting directly medical care, and thereupon, hospital services and also insurance sector for the last years. It is a widely held view that change and transition are based on two fundamental points. First is the financing of healthcare services, named the Public-Private Partnership Model. The second is the provision of healthcare. In this chapter, the privatization journey of Turkey will distinctly be

emphasized as what it has been experiencing. Finally, the City Hospitals will be analyzing as the last example of privatization winds in health in Turkey.

4.1. The ELEMENTS OF HEALTH SECTOR

4.1.1. The Finance of Healthcare Delivery

The public institutions and private actors have always been acting in unison in the context of the finance and delivery of healthcare. In addition to these, the foundations without profit-making purpose are delivering healthcare. However, they make money at a reasonable level even if they are non-profit institutions. Besides, the public element in healthcare delivery is based upon that the finance source is coming from tax revenue or compulsory participation-oriented insurance system. In this picture, the leading role concerning planning and balancing the system is perpetually belonging to the state, even if private actors are second game-founding.

Medical technology and drugs development and the rise of life expectancy caused the need for institutionalization in the healthcare area in the second half of the 19th century. Moreover, after the Industrial Revolution, the need for a healthy labor force and the need for over-consumption led to growing European economies. That is why the determination of health policies has emerged.

Within this process, the compulsory participation-oriented system firstly emerged in Germany, named Bismark Model, based on social insurance. The founding father of this model is German Chancellor Bismark. The contributions to the system are taken with salaries, however, employer and state contributions are the other and huge components of this system. These allowances are being compounded in social insurance funds (Herman, 2010). That system has still been implemented by most

of the countries including Turkey, with the compulsory interruption provided by worker wages, employer, and the state contributions although it has been modifying.

The other model emerged in England in the 20th century. National Health Service (NHS) was established in 1945, named Beveridge system, and foundation hospitals without profit-making purpose and health facilities of local authorities were united. The finance belonging to the health service is provided by taxes that are levied according to the income level of the citizens. The system allows private health insurance to exist as well. The person that demands health services can pay for health costs over private insurance. However, the healthcare service is commonly provided by the state. This hybrid system is implementing across a lot of Southern and Northern European Countries as well, outside England (Herman, 2010).

In other words, The Beveridge model aims to provide preventive and therapeutical healthcare services to all citizens on an equal and equitable basis by financing from general tax revenues. The most significant factor determining the rate of the tax in the financing of the system is the extent to which the society will assume the collective responsibility through public means. The Bismarck model, on the other hand, is based on the insurance system and is premium-oriented. The funds are financed by contributions. However, both models can contain have out of pockets payments the extent to different proportions.

The third model is the Private Health Insurance Model. The individuals insure their own health risks in that system. Private health insurance can be used at different levels and purposes. For example, on the one hand, the private health insurance model in some countries such as the USA is adopted as a financial model for the overwhelming majority of the population; on the other hand, it is regarded as having a supplementary role in common with the public system like in European countries.

In other words, it is used in the portion that the public system cannot afford in order to provide finance.

The amount that individuals have to pay to the private actors is associated with health status and health risks in the private health ınsurance system. More clearly, the individuals that have to struggle with any illness such as diabetes mellitus and hypertension or have more illness risk like people using tobacco and alcohol have to pay more to the system contrary to the other people. It means that a private insurance actor has to make much more money from people who have more health risks in order to survive. It is called 'adverse selection'. Therefore, the individuals who face fewer health risks or do not have health risks will not be able to be eager to pay to the system. Thus, mostly the individuals facing more health risks will exist in the private insurance system. It leads to unbalance of income and expenses and the continuity of the finance has adversely influenced (Tatar, 2011).

Contrary to the private insurance system, the premiums that individuals have to pay are in conjunction with income and tax in social insurances. Besides, social insurances are predictable and based upon social solidarity. According to the principle of solidarity, individuals are not regarded as independent existence. Therefore, equal access and the fact of social justice are philosophical approaches that can be created by the principle of social solidarity belonging to social insurance.

Moreover, the case of the USA is a significant example within the case of the private insurance system. The Health System of the USA is basically a private system based on a mixed-functional structure including social premium. Besides, Medicare and Medicaid programs exist. More clearly, there is a three-fold structure. 1) program that meets the expenses of military forces, and models like Medicare, Medicaid financed by the general budget 2) fully payment of out of pocket 3) employment-oriented insurance program. The rate of all these programs that meet expenditures

is limited and individuals that demand healthcare services have to pay in various proportions. Medicaid delivers healthcare services to Americans including low-income adults, children, disabilities, pregnant women. It is managed by the states in the USA and financed by the states and federal government. Medicare also delivers healthcare services to the elderly. It is financed by complementary social insurance trust (Kırılmaz, Amarat, & Ünal, 2017).

Within this context, whichever model is chosen, it is necessary to focus on the issues that need to be addressed first and the questions that need to be answered. According to Roberts et al. (2004), when examining a financing model or evaluating its impact, first of all, the impact of the selected model on equity, the degree of risk pooling and its impact on the general economy should be considered. Regarding these issues, it is important to ask the following questions:

1) Who bears the financial burden? When it is considered in terms of all risk groups from low-risk groups to high-risk groups, to what extent does the chosen financing method protect high-risk groups? The answers to these questions are the most significant determinants of the degree of equity of the chosen method. The fundamental principle in the financing of health services is to ensure a flow of finance from individuals with high income and better health status to individuals with poor income and worse health status. In other words, no matter what financing model the funds are collected in a pool, those who have high incomes contribute more to that pool in the proportion to their income; but since their health status is better, they ought to use that pool less. In cases where it works contrarily, very significant problems will have arisen in terms of ensuring equity in the financing of health services.
2) What could be the economic effects of the financing method, such as encouraging investments and employment opportunities? Establishing the connection between the general economic balances and the financing model of health services is an extremely significant component in ensuring the

sustainability of the system. For example, in a country where the social insurance model is adopted, the high amount of premiums to be received from employees and employers might adversely influence the employer's decision to have new investments and create employment or might lead to the rise of the informal economy. The same situation is valid for tax rates. In this case, due to the difficulties encountered in the creation of financial resources, the pool might not be able to collect enough funds to meet the health needs of the society and the health service provided may be negatively affected in terms of quantity and quality (Roberts, Hsiao, Berman, & Reich, 2004).

The privatization and commercialization process has been drastically soaring since the 1980s, as had been highlighted hitherto. Notably, in the 1990s, ınternational institutions and capitals had suggestions and demands regarding making investments in health. In other words, health has been started being regarded as a luxury area in order to make profit-maximization. Furthermore, it is seen that private activity has been penetrating in both Bismarck Type Health System and National Health System. More vividly, privatization has been widely expanding since the last four decades in the field of health. In the beginning, the traditional privatization method has dominated in the case of investment in the private hospital, by running market rules. However, day by day, intermediate formations such as the separation of financing and service delivery have been enforced. The separation of financing and service delivery has led to subcontracting in health service delivery. The structure, which was seen as the subcontractor supply of areas such as hotel management, catering, and cleaning services at the beginning, has gradually become to contain health services that include high knowledge and technology. These subcontracting agreements have been transformed into public-private partnerships in the long term. The change seen after the emergence of these structures was the flexibility of working conditions and the reduction of

employment in order to reduce costs. In total, the number of health workers in Europe decreased by 25% between 1980 and 2005 (Herman, 2010).

Turkey has also been facing that situation Herman mentioned in the example of European Countries. Justice and Development Party has paved the way for the increased rate of the private actors in Health thanks to Health Transformation Programme, declared publicly in 2003; and thereupon, a suitable political and economic atmosphere has been created in order to enforce the PPP model's fusion in Healthcare. It will be analyzing in following parts.

4.1.2. Labour-force in Health: Health Workers

Labor - power may be seen as the sum of the mental and physical abilities that a person has and expends while producing anything. It is the main component of production. The survival and reproduction of labor power is a strict condition for the reproduction of capital in capitalism. Labor is also based on social cooperation and is productive activity. It, therefore, takes a specific form in social conditions that are exchange value or commodity production. This is called wage labor in that social conditions (Göçmen, 2009). Although the production of health services does not appear as a commodity production in practice, it can be said as one of the absolutely necessary factors for the existence and continuation of a healthy labor-power that produces commodities and surplus-value. Therefore, since health services can affect the production process, they must be taken into account by the capital owners in the case of the reproduction of capital.

Health care production needs intensive labor-power of different qualities. It mostly requires advanced technology, so it is applied by highly skilled workers. In addition, the service provider and the recipient are in a direct relationship. This service is a

type of service that is demanded at all hours of the day. It is the result of teamwork. Besides, it cannot be replaced by another type of labor power.

Neoliberalism has drastically influenced health labor and health workers' personal rights at the same time. The production process consists of the sum of dead and living labor. The source of the value created as a result of the production process must be sought in either dead or living labor. Dead labor is transferred to the product in the production process as the price and quantity given as use-value in the circulation process. Thus it shows itself in the cost accounts. Therefore, the only variable that can be influenced is living labor: that is, healthcare workers (Ercan, 2013). When we look at the change that has taken place in the field of health, we can see that one of the important elements of the change is to include health workers as variable capital for unpaid labor time, that is, as living labor. In other words, while patients turn into customers in the process of marketization in healthcare, healthcare professionals turn into hospital workers in the process of commodification.

In systems where health care financing is fully provided by the public, labor remuneration is generally structured as a fixed salary, and the health labor provider has the status of the civil servant. In systems where health financing is covered by private insurance companies and hospitals are in the hands of capital groups, the fee is determined by paying a certain proportion of the collected cost of the health service, which is generally produced over a basic minimum wage, to the health labor provider. There are different policies determined according to the emerging market conditions in the remuneration of the highly diverse health workforce.

4.1.3. Medication: Pharmaceutical Companies Investments

The pharmaceutical industry is a significant industry that plays a critical role in protecting the health and improving the quality of life, which is the most basic need of people. The pharmaceutical industry, which produces for health, has a dynamic structure today with the effect of prolongation of people's life span, increase in quality life expectancy due to increases in income level, environmental factors, and technological development. The pharmaceutical industry has an significant role in protecting human health and improving the quality of life as well. It also has economic and strategic importance within countries. The pharmaceutical sector, which is accepted as the third sector in the world, is one of the earliest established sectors in Turkey.

Since the beginning of the 1990s, there has been a rapid growth in the share allocated to pharmaceuticals in health expenditures in the world. The world market has been boosting every year in the pharmaceutical industry, where there is perfect competition between companies and many company acquisitions and mergers are experienced. It is known that the pharmaceutical industry has grown approximately 10% per year since 1999, and in 2008, sales revenues worldwide reached 775 billion dollars (Applbaum, 2010).

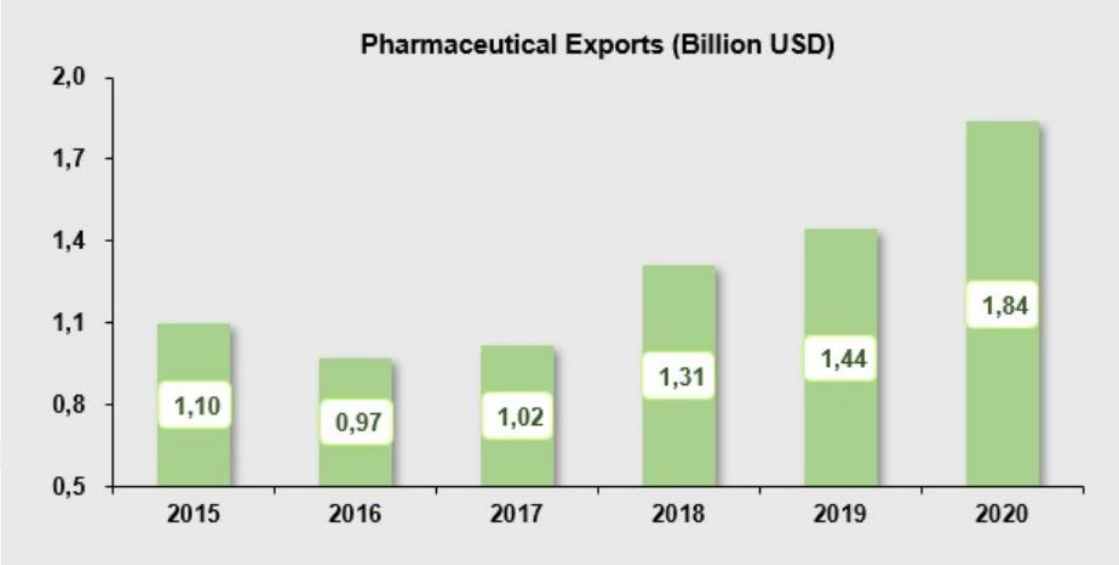
Pharmaceuticals account for approximately 18% of healthcare expenditures across the earth. Among the reasons for this development, there are two points that need to be especially evaluated. These two structures are called medicalization and drug orientation. As medicalization, it is defined as a condition that was not a disease that needed treatment before, and now it is defined as a disease and directed towards treatment. The media is also used to encourage individuals to seek treatment for conditions that are included in medical guidelines as disease, possible dysfunction, and are not previously defined as a disease. In addition, making changes in the

definitions of some diseases and enlarging the pool of 'sick individuals' that need to be treated is also included in these medicalization manipulations (Applbaum, 2010). It is vividly seen that consumption concerning pharmaceuticals is encouraged in order to increase sales, due to the fact that the market rules have been fully dominating drug industry. Curative health expenditures are less costly than preventive health expenditures. For this reason, the importance of preventive health services will never be lost in terms of the understanding of the social state. People who lost their health are trying to regain their old health by applying drugs with the advice of doctors, but there is a significant thing that should not be ignored, which is, that people's health depends on the pharmaceutical industry.

The total trade volume of the pharmaceutical industry in the world is over US$ 1.42 trillion. Intensive consumption in developed countries is also met by production in developed countries. According to Trademap 2019 data, world pharmaceutical exports are 695 billion USD. The top 10 countries in pharmaceutical exports account for 77% of total exports. The top 5 leading countries in world pharmaceutical exports are Germany, Switzerland, Ireland, the USA, and Belgium, respectively, and the exports of these 5 countries account for more than half of the world's pharmaceutical exports. Turkey ranks 29th in the export ranking (The Ministry of Industry and Technology of Republic of Turkey, 2020). Turkey is also a country the drug industry has been growing.

According to the Pharmaceutical Manufacturers Association of Turkey data's, although Turkey faced a decrease in export proceeds, in 2020, pharmaceutical exports increased by 27.3% and reached US$ 1.84 billion on the annual basis (Pharmaceutical Manufacturers Association of Turkey, 2020).

Table 1. Pharmaceutical Exports (Billion USD)



Source: Pharmaceutical Manufacturers Association of Turkey, 2020

According to the same data, the Turkish pharmaceutical market also reached 40.7 billion TL with a 31.7% growth compared to the previous year on a basis of value in terms of the hospital and pharmacy, and 2.37 billion units with an increase of 3% on the box scale in 2019. In the last decade, the sector has grown by approximately 300% based on value scale and 46.3% based on a box (Pharmaceutical Manufacturers Association of Turkey, 2020). However, the Turkish pharmaceutical market declined in 2020. The reason why it decreased could be based upon being Covid19 and its influences on all economic and political areas.

Table 2. Turkish Pharmaceutical Market

Source: Pharmaceutical Manufacturers Association of Turkey, 2020

As it is known, a patent is the right of the inventor to produce, use or sell the inventive product by protecting it from competition for a certain period of time. The patent term, which means that new inventions are protected within the scope of intellectual and industrial property rights for a certain period of time, is 20 years all over the world. In the pharmaceutical industry, patents are obtained for the original drugs developed. The competitiveness of pharmaceutical companies is determined by the original drugs that have been developed to a large extent and the patents obtained for these drugs.

What makes the drug different from other economic products is that it is non-substitutable. That is, a product other than medicine cannot be used in place of necessary medicine. Therefore, drugs with an exchange value are indispensable products, whatever their price. This feature of the drug shows why the pharmaceutical industry is the most critical sector of the world economy today (Petrol - İş Araştırma, 2010). As it is seen that, pharmaceutical production is a huge

sector. Private activity has shouldered the rate of the lion concerning production, sales, and profit in the medication area.

4.2.HEALTH TRANSFORMATION PROGRAMME

4.2.1. The Preparation Process of the Transition

Health reform efforts in Turkey gained momentum after 1990. Within the framework of the "Health Sector Master Plan" commissioned by the State Planning Organization (DPT) in 1989 and completed in 1990, the first Health Project was carried out supported by the World Bank. As a result of this study, a reform proposal has been made in the Turkish Health System, where the service provider and the service buyer are separated. The Master Plan Work later accounted for the basis of the reform studies that have been accelerating at the Ministry of Health.

The Health Project Loan Agreement (Loan No: 3057-TU) was signed between the Government of the Republic of Turkey and the WB on 16.08.1990 (Official Gazette 20658: 1990). The total budget of this project is 150 million dollars and 75 million dollars of the total budget was given to Turkey as a loan. With this project, it is aimed that the health system will have a high quality and partially self-financing structure. Besides, according to the loan agreement, Health Project General Coordinatorship was established. The coordinatorship has changed to catch up on the changes and work more 'efficiently'. Lastly, it has been named "Project Management Support Unit" in 2004, by the Ministry of Health.

The loan agreement for the Second Health Project was signed between the government of the Republic of Turkey and the WB on 28.09.1994. The budget of the project is 200 million dollars and 150 million dollars of the total budget has been given as a loan by the WB. Although the aim of the second project is similar

to the first one, the basic legal and political infrastructure of the project, which will later be called Health Transformation during the AKP governments, was prepared. Both projects include the years between 1990 and 1999 (Belek, 2012).

The first draft National Health Policy document was published by the Ministry of Health in 1990, and it was stated that the purpose of this document was to "create an unchanging health policy with the changing government and ministers". For the first time in the health policy determination process, all parties related to the health sector with a participatory and conciliatory came together at the First National Health Congress in 1992. A comprehensive study on the organization of the health sector was carried out with the participation of 500 people, including the relevant sector, institution, university, professional association, and the press. Based on the reports prepared by 35 working groups, this document, which took its final form after being discussed with both the World Health Organization and in the Second National Health Congress held in 1993, became the focal point of the discussions on reforms (Yılmaztürk, 2013).

Within this framework, the main headings of the health reform studies carried out in the late 1990s and 2000s can be listed as follows: 1) Establishment of General Health Insurance and social security the gathering of institutions under a single umbrella. 2) Separation of service provision and financing functions. 3) Restructuring of the Ministry of Health to effectively perform health services planning and supervision tasks. 4) Giving autonomy to hospitals 5) Giving priority to preventive health services. 6) Development of first level services within the framework of Family Medicine.

The first phase of the Health Transformation Program was carried out with the agreement between WB and the Ministry of Health. It was signed between the Ministry of Health and WB on 20 May 2004. The total budget of the project is 71.22

million dollars. 56.36 million dollars of this total budget was financed by DB. The project was extended until 2008 with an additional protocol signed (Belek, 2012).

For the Health Transformation and Social Security Reform Project, a new phase was started with the agreement signed between WB and Social Security Institution (SGK) on 30 June 2009. A debt agreement has also been added to the new project. A loan of 75.12 million dollars was given to Turkey by the WB. The project covers the period until July 2013. The project aimed to increase the efficiency of the SGK and the Ministry of Health in purchasing services, make the entire health system more effective, and prevent diseases. Structuring the Ministry of Health, transforming health care institutions into independent or semi-independent status, switching to family medicine practice and referral system, making the SGK reach the desired inclusiveness and purchasing services from the institutions producing health services, and the application of receiving contribution from patients. are among its aims (Belek, 2012).

During Turgut Ozal's Governments, the “Foreign Capital Framework Decision” aimed at the entry of foreign capital to the country and were in “co-operation” with foreign capital were implemented. However, mainly, precautions that generously invite foreign capital investments were provided by Justice and Development Party with “Foreign Direct Investment Law”. These regulations have enabled foreign capital to invest in previously thoroughly un-commercialized areas such as healthcare. These advancements allow foreign capitalists to invest in healthcare. The aim has been opening health to become a lucrative area since the 1990s. Therefore, the rate of foreign capital and private investors has been sharply increasing in healthcare. The state's role is just regulatory, enables to competition to realize, such that according to The Prime Ministry Investment, Support, and Promotion Agency legal regulations in order to pursue the policies in 2010. Especially since 2004, Turkey has attracted many well-known multinational

companies operating in different sub-sectors of the healthcare industry. Many international companies are establishing production bases in the country to take advantage of Turkey's geographical location, qualified human resources in production and management, and unsaturated domestic market with high growth potential. In order to attract foreign investors to the Turkish market to invest, Turkey offers various incentives as well: 1) New R&D law providing incentives to invest in pharmaceutical R&D studies 2) Repealing some of the conditions that foreign investors were required to meet as per the procedure 3) The transfer of shares or the establishment of partnerships of companies with foreign investors is not subject to the approval of the General Directorate of Foreign Capital (YSGM). 4) Foreign investors can choose among various solutions, including international arbitration, for commercial disputes arising from transactions in Turkey. In addition, the following factors vividly indicate a fundamental liberal approach: 1) Freedom to export the profits made by foreign investors in Turkey 2) Freedom for foreign investors to acquire real estate or rights in Turkey 3) Freedom to own up to 100% of a Turkish subsidiary." (The Prime Ministry Investment, Support, and Promotion Agency, 2010).

Within this framework, healthcare has been widespread reconstructing since 2003. The first Justice and Development Party government declared the principles of this structural transformation in the "Emergency Action Plan" announced in 2002 with the slogan "Health for All". The main objectives of the emergency action plan, gathered on eleven basic items, are listed as follows: 1) Administrative and functional restructuring of the Ministry of Health 2) Inclusion of all citizens in the scope of general health insurance 3) Gathering health institutions under one roof 4) Making hospitals autonomous in terms of administrative and financial 5) Switching to family medicine practice 6) Paying special attention to maternal and child health 7) Dissemination of preventive medicine 8) Encouraging the private sector to invest in healthcare 9) Delegation of authority to lower levels in all public institutions 10)Eliminating the shortage of health personnel in priority regions for development

11) Implementation of the e-transformation project in the field of health. In the light of these goals, Health Transformation Programme has been implementing. Three fundamental headings are significant: 1) Ministry of Health has now regulatory role 2) Autonomous Health Facilities built in terms of administrative and financial such as Family Practice 3) Ensuring the financing of the system with general health insurance by establishing the social security system structure gathered under one roof (Akdağ, 2007).

In addition, the regulations regarding the finance of health facilities have made in the following a couple of years. These are the key to the transition. The Public-Private Partnership Model passed into the law, with an additional article on Health Services Basic Law numbered 5396. in 2005. The Department of Public-Private Partnership was established in the law numbered 5683 enacted in 2007 (Erbaş, 2021). Thus, the complete privatization of healthcare started to be implemented, and thereupon, city hospitals have been started to build.

In addition, Yılmaz underlines that after Health Transformation Programme the private activity in healthcare services has been sharply increasing. The number of private hospitals has drastically soared. Within this context, bed capacity has been increasing, however, the rate of bed capacity in private activity evenly goes up. The number of Private Hospitals has been increasing almost four times between 2002 and 2015. It shows clearly that privatization in healthcare provision is chosen and promoted (Yılmaz, 2017).

4.2.2. The Family Practice

There are three levels of health services in Turkey. Primary Health Care Services were provided by Family Health Centers and Community Health Centers. Secondary Health Services are provided by state hospitals. Third Level Health

Services are provided by 'Training and Research Hospitals' belonging to the University and the State.

With the Health Transformation Program, Family Medicine replaced the Health Centers established by the Socialization Law. The 'Family Practice Pilot Implementation Law' No. 5258 was published in the Official Gazette No. 25665 dated 24 November 2004 and entered into force.

According to the relevant Law, some features of family medicine can be listed as follows: the basic unit is the “family health center”; this unit consists of a family physician and a family health personnel (nurse/midwife); everyone living in the country will choose a family doctor; each member of the family can also choose a different physician at the same time. Those who live in the city center will have the freedom to choose a physician, however, people living in rural areas will not be able to choose their physician. The Provincial Health Directorate will direct each village to the nearest family doctor whose list does not have enough people who are registered. Thus, the people of the village will be able to receive service from that doctor. A minimum of 1000, a maximum of 4000 people will be able to register a family doctor. In return for the freedom of individuals to choose a physician, physicians will also have the freedom to choose a person (patient). Family physicians will be able to operate a medicine cabinet, make home visits, and provide mobile services in the villages connected to them. Payments of family physicians will be made in accordance with the “capitation”model. Family physicians will be paid per job for those that are not included in the service package to be covered by the capitation (Resmi Gazete, 2004).

The most significant challenges of family medicine practice can be considered as access and unequal distribution. The system is focused on developed regions. It

eliminates the equal access of Health Centers coming with the Socialization project that provide services even to those who live in the farthest corners.

The new system had tried firstly in Duzce. The brief experience of the pilot implementation in Düzce has interestingly begun to emerge. In Düzce, the percentage of vaccination has decreased, family planning practices have regressed, and rivalry among physicians has begun to appear. Another striking feature of the Düzce implementation is its lack of programming (Öztek, 2006).

4.2.3. General Health Insurance

The second significant pillar of the Health Transformation Project is the development and the implementation of Social Security and General Health Insurance, which gathers all citizens under a single security umbrella. Thus, all public health institutions other than the Ministry of Health (except university and military hospitals) and hospitals belonging to the Social Insurance Institution were transferred to the Ministry of Health.

In addition, the Social Security Institution was established with the law numbered 5502 dated 20.05.2006 and the fragmented structure of the social security system was combined under a single roof. The Social Security Institution took over the entire system of SSK, BAĞ-KUR, Retirement Fund, and Green Card holders. Thus; it also took over the works such as collecting premiums, paying pensions, covering health expenses and etc. (Resmi Gazete, 2006a)

Furthermore, after the establishment of the Social Security Institution (SGK), everybody who lives in Turkey was included by General Health Insurance within

the scope of structure and mechanism of SGK with the law of “Social Insurances and General Health Insurance”dated 31 May 2006. (Resmi Gazete, 2006b)

One of the most significant downsides of developing countries in the field of social security is coverage. It is difficult to provide services to the entire population in systems where access to social security is associated with employment. Moreover, this problem is much more difficult in countries with informal employment. Turkey has also been suffering from informal employment. According to Republic of Turkey Social Security Institution data, even if the rate of informal workers has been declining from 2003 to 2020, the proportion of 2020 -approximately %30- is excessively high. In other words, approximately %30 of all workers do not have any social security. Besides, considering the number of jobless, which is out of coverage, the picture is being darker. Besides, regarding as sectoral, agriculture, the area so to say that the poorer people work, has the most informal employment part. These all means that the system also suffers from deficient contribution. In addition to full informality, that is the other context of informality, called deficient informality (Yaşar, 2011).

In addition to informal employment, due to the absolute obligation to pay premiums, in case of indebtedness, the insured people might not be received health care services. Considering the high rate of general informality, the premium cannot be paid to the system. This literally means that the main goal is not to cover all citizens in order to access healthcare. However, during that period, notably abolishing the caste system in health institutions and access to every hospital had been working well for paving way for the neoliberal policies. It seems that General Health Insurance gives the citizens a limited assurance packet.

Table 3: The rate of Informal Employment in Turkey

Year	Agriculture	Non-Agricultural	Industry	Service Sector	Construction	General
2003	91,15	31,55	36,43	29	-	51,75
2004	89,9	33,83	37,28	31,96	-	50,14
2005	88,22	34,32	38,11	32,27	-	48,17
2006	87,77	34,06	38,12	31,88	-	46,97
2007	88,14	32,34	35,51	30,63	-	45,44
2008	87,84	29,76	31,61	28,77	-	43,5
2009	85,84	30,08	33,43	28,4	-	43,84
2010	85,47	29,06	32,68	27,11	-	43,25
2011	83,85	27,76	31,5	25,71	-	42,05
2012	83,61	24,51	27,89	22,73	-	39,02
2013	83,28	22,4	25,23	20,9	-	36,75
2014	82,27	22,32	20,26	21,09	36,61	34,97
2015	81,16	21,23	19,13	20,05	35,58	33,57
2016	82,09	21,72	20,2	20,35	35,76	33,49
2017	83,33	22,1	20,03	20,95	35,8	33,97
2018	82,73	22,28	20,29	21,46	34,39	33,42
2019	86,62	22,96	20,03	22,55	37,74	34,52
2020	83,46	19,3	16,46	18,76	34,72	30,59

Source: Republic of Turkey, Social Security Institution, Data Accessed: 25.09.2021, retrieved from http://www.sgk.gov.tr/wps/portal/sgk/tr/calisan/kayitdisi_istihdam/kayitdisi_istihdam_oranlari/kayitdisi_istihdam_orani

After about one year, the other step came into the Turkish agenda. Social Security Institution Health Implementation Communique (Sağlık Uygulamaları Tebliği) was published in the Official Gazette No. 26532 dated May 25, 2007. Thus, it was ensured that all citizens could receive services from all private health institutions that made an agreement with the Social Insurance Institution (Resmi Gazete, 2007). This clearly shows that the fundamental aim was based upon paving way for the privatization.

In the Health Implementation Communiqué, diseases are defined as "packages" under certain headings. The fees to be paid for these packages have been determined by the Social Security Institution. The rules of health services to be purchased by the Social Security Institution from private health institutions are determined by this communique. Apart from the fee they receive from SGK in return for the services they provide, private hospitals are also allowed to receive a difference fee of up to 30-90% over this package price determined from the patients.

The other fundamental change of health transition program is "contribution" in order to get health service. The other fundamental change of health transition program is "contribution fee"in order to get health service. It has been started to collect contributions from those who apply to private hospitals/polyclinics for examination and from those who apply to public hospitals to extent of steps they want to get healthcare service. In addition, the "drug contribution fee"per unit drug in the prescription has started to be taken for the treatments (Resmi Gazete, 2006b). Besides, the additional difference fees charged in private hospitals have increased the number of health expenditures made directly out of pocket by citizens. This is a demonstration that health progressively becomes more privatized and becomes a commodity that can be bought and sold according to market rules for profit

maximization. More clearly, Healthcare services have been posing privatization since the beginning of the Health Transformation Program.

4.2.4. The Revolving Funds in Health

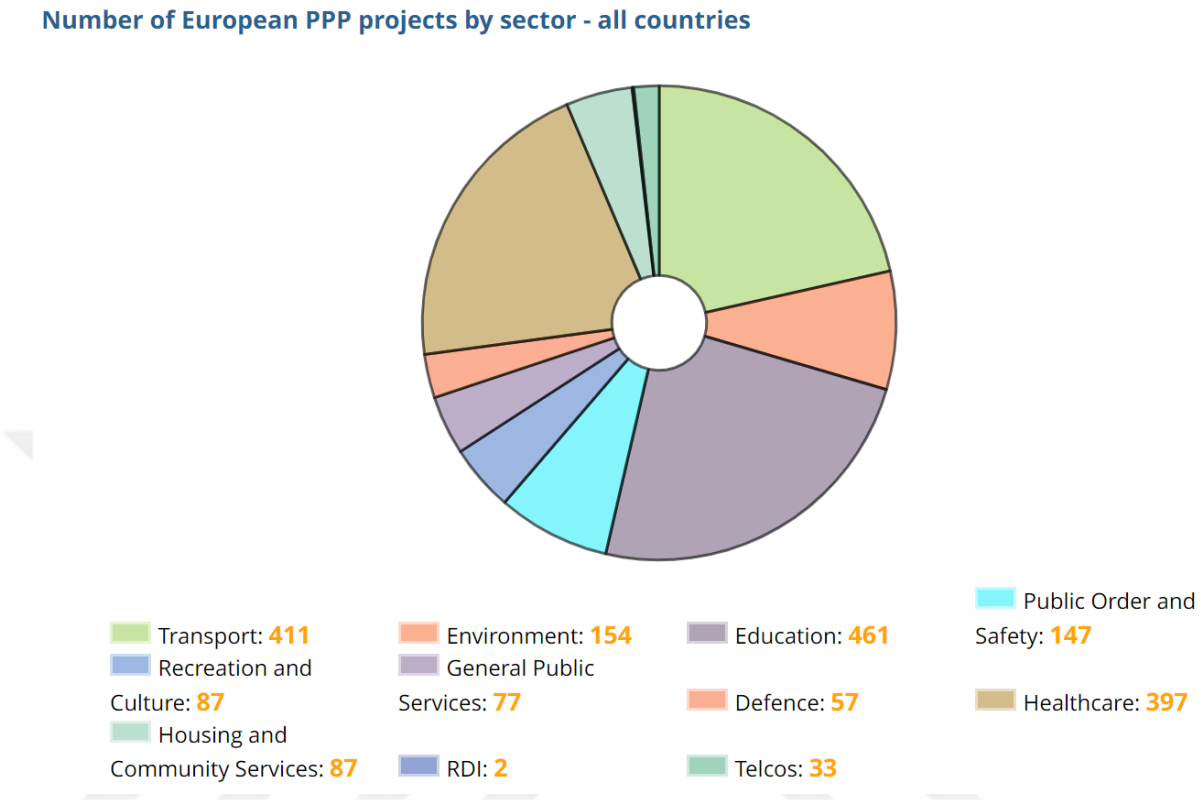
Although the implementation of revolving funds is new, the law concerning it is old in Turkey. The establishment of revolving fund enterprises in all institutions affiliated to the Ministry of Health is based on the Law No. 209 enacted in 1961. The full name of the law is " The Law on Revolving Funds to be Given to Health Institutions and Rehabilitation Facilities affiliated to the Ministry of Health" (Resmi Gazete, 1961). This law has been amended many times and the most detailed amendment was made in 2005 with the law numbered 5335. After the adoption of the "Law on the Transfer of Health Units of Public Institutions and Organizations to the Ministry of Health", revolving funds were established in the SSK hospitals that were taken over.

Despite the fact that it is included in the law enacted in 1961, no fee was requested from the citizens within the scope of social security in return for the health services provided until the contribution fee came into effect. However, the "Health Transformation Project"dictated public health institutions and organizations to finance their services with their own revenues. Therefore, there was a need for the implementation of contribution margin. In other words, the scope of social insurance started drastically to be declined. In fact, contribution fees have been increasing since that time and the scope of pharmaceuticals has been decreasing. The last example of it is declared publicly in the official journal. 52 pharmaceuticals have withdrawn from reimbursement of social insurance, including painkillers and carisoprodol. (Resmi Gazete, 2021)

4.3. PUBLIC-PRIVATE PARTNERSHIP MODEL

The need for infrastructure services has been increasing worldwide. For reasons such as population growth, urbanization, and natural wear; More and more expenditures are made on infrastructure investments such as hospitals, airports, bridges, and roads, which pave the way for long-term economic growth. While developing countries need to renew their outdated infrastructure investments, developed countries want to expand their infrastructure networks. In a study conducted for PricewaterhouseCoopers, it is stated that the annual infrastructure investment expenditures, which reached 4 trillion USD worldwide in 2012, will exceed 9 trillion by 2025 (Abadie, 2014). Another consulting firm, McKinsey, predicts that in the 17 years between 2013 and 2030, 57 trillion US dollars will be needed to finance the infrastructure investments needed (Mc Kinsey & Company, 2013). In order to meet such high resource needs for financing infrastructure investments, governments are increasingly turning to project finance from the private sector. Between 1998 and 2008, there was a 5-fold increase in private sector financing for infrastructure (Abardie, 2008). In 2010, a US$ 4 billion Public-Private-Partnership agreement was signed in the health sector worldwide (Roehrich, Lewis, & George, 2014). Besides, When the sectoral distribution of public-private partnership projects implemented in the European Union countries in 2021 is examined, it is seen that 397 of 1799 projects are in the field of healthcare. (EPEC , 2021)

Figure 3. The Number of European PPP Projects by Sector – All Countries



Source: EPEC Data Portal, Data Accessed: 30.09.2021, retrieved from https://data.eib.org/epec

Although nevertheless PPP has been discussed in neoliberal era and globalization fact as a part of commercialization and privatization, notably since 1990s, there are instances that can be evaluated as PPP in the history of the world. The beginning point of PPP is can be regarded as the road construction projects in England in the 1660s based on participation of the private sector. Especially after the industrial revolution, with the canal and railway projects, the implementation of the public private partnership model reached the highest level in the 1860s, however many investors have went bankrupt with the economic crisis in Europe. In addition to the UK, the PPP model was also applied by the United States and France. Besides, the Suez Canal Project, which was also supported by the Governor of Egypt, Said

Pasha, and completed in 1869, is evaluated as a product of public-private partnership. (Boz, 2013).

The involvement of the private sector in public services is the implementations of "joint venture" that have widely used, onwards early periods in America. The Public Private Partnerships were expanded owing to the "Private Finance Initiative (PFI)" initiated by John Mayor in 1992 in England and the "Best Value" projects in the Blair period (Yeşiltaş, 2020).

The public-private partnership has no specific definition commonly held in international consensus. It can be generally defined as long-term contracts signed by cooperation between the state and private sectors (World Bank, 2014). The private sector has been undertaking risk management and earning income in proportion to its service. The service remuneration is paid by the users and/or taxpayers - public enterprises/authority-. For example, in the Turkish case, the service remuneration of the City Hospitals which are built by PPP contracts is paid by the budget of the Ministry of Health. (Emek, 2018). Despite the fact that 'partnership' is new, similar models - in similar names such as Build Operate Transfer, Cooperation between Public and Private, etc in Turkey and Public Finance Initiative in England- in a variety of areas have been implementing since the 1980s. The main purpose is the same to invest in uncommercial areas, which means that the private sector and the state cooperate in the neoliberal era (Çal, 2018). In other words, privatization is not only to sell public resources but also comprehensively the transfer of public budget to private actors. PPP or the other names of it is the means of it. In this study, the concept of Public-Private Partnership will be used afterwards.

Furthermore, a contract is considered a full contract if it can anticipate and differentiate all future developments. In such a case, the courts and/or third parties

that will execute the contract can fully understand/interpret the provisions of the contract and the intentions of the parties. However, problems in PPP contracts arise from long-term and incomplete (complex) contracts written in the uncertainty of the future. Incomplete contracts may contain gaps, uncertainties and incomplete provisions; therefore, they must be revised during the implementation process, either through negotiations between the parties or by the courts (Baker & Krawiec, 2005).

Briefly, it can be as regarded as that the PPP regime is a form of privatization. When we think of the health sector, the public authority delegates the management of a public hospital to a private company (franchising). The private company builds institutions according to the needs of the public. It also finances fixed capital investments. Thus, it takes over the management of this institution. The government guarantees to get services for a certain period of time on the condition that the ownership of the institution remains with the private company. This period is usually 30 years. The government takes back the ownership of the institution when the term expires. The private company builds the hospital, operates it for a certain period of time, and then transfers the institution back to the state. In other words, the private company builds the hospital and transfers it back to the public after a certain period. In other words, the private company builds the hospital, operates it, and gives it back at the end of its term in the contract (McKee, Edwards, & Atun, 2006).

The strategic rationale for choosing PPP contracts in healthcare is the access to private sector resources and cost savings. Although both privatization transactions and PPP contracts aim to involve the private sector in the delivery of public services to increase efficiency, they are very different from each other. Private hospitals establish their relations with patients independently of the state. The administration/government is responsible for regulating matters such as price,

quality, and safety that concern patients. Apart from these, it does not undertake any risk of the project. In this framework, privatization transactions are based on the “full contract” approach, which recognizes that market imperfections result from “adverse selection” and “moral hazard” problems. (Emek, 2017).

However, the government, thusly the public treasury, has undertaken a liability based on rental allowance regarding hospitals which is built by private companies and payment concerning particular services provided by the private companies. Therefore, it is a different point of classical privatization rituals that is holly for the free-market rules, by containing huge and long-term concessions and encourages, and whereupon, it cannot be depicted as three partnerships included the citizens, the state, and the private actors. This is because there are two actors in the frame of PPP - the rulers and the private companies-. The rulers have been deciding that the public budget is used for the sake of private activities. Therefore, it also ought to be read related to that reorganized of the capital and reproduced of the capital. More clearly, unique areas such as health that must be based upon equal access have been sharply opening to investment from every aspect. This is not classical privatization, what's more, it is a more comprehensive privatization attack on public healthcare services.

Besides, international institutions, too, such as IMF pays attention to which the PPP models that have expanded starting from north countries to south countries can adversely influence the states' budget. Therefore, IMF suggests that it should be limited in a particular point and period. The IMF, in its report published in 2016, underlines the adverse effects of such long-term contracts by giving examples across the globe:

“Large fiscal costs and fiscal risk have arisen from PPPs in both developing and advanced countries. Both traditional procurement and PPPs share common project risks, such as construction and demand risks. However, the above government bias

and possible manipulation of PPPs add an important layer to the common project risks. An inadequate budgetary and/or statistical treatment may allow governments to ignore the impact of PPPs on public debt and deficit. In practice, governments often end up bearing more fiscal costs and risks than expected in the medium and longer term" (Jin & Rial, 2016).

The European Union also draws attention to 4 points in its analysis of Public-Private Partnership in health service delivery. 1) A measurement-based discussion is required in the PPP model. 2) It is considered whether the investor should bear more risk for future contracts without increasing costs and discouraging investments. 3) PPP contracts must take into account the reality of increased health expenditures. 4) Requesting more government support for PPP projects is not a long-term solution (European Union, 2014).

In addition, as a result of the widespread and rapid development of PPP models notably since 1990s, the European Commission has worked on these models, and accordingly, in April 2004, it has published "Green Paper on Public Private Partnerships and Community Law on Public Contracts and Concessions". The principles related to public contracts and concessions are determined in the study.

The EU commission emphasizes the four main defining features of PPPs. Firstly, a planned project requires a long-term partnership relationship that includes the cooperation of a public partner and a private partner at different stages. Secondly, a project will be financed partly by the private sector, sometimes through complex arrangements between various actors. As the thirdly, The significant role of the economic actor involved in the different stages of the project -design, construction, implementation, financing- has been mentioned. Within this context, the public partner should mainly focus on determining the targets to be achieved in terms of public interest, the quality of public services provided by the other actor and the

price policy. Besides the public partner should monitor the working process that is suitable for the targets or not. Fourtly; In the distribution of risks between the public partner and the private partner, the factor of shifting the risk from the public partner generally undertaking, to the private partner is emphasized. However, while the private partner does not have to shoulder all the risk, or even the most of the risk involved in the project, the decision on who to bear the risk differs from project to project, based on the partners' agreement (Comission of Europen Communities, 2004).

PPP has been widely method in healthcare in the world since the last of 1990s. In the UK, the private sector, one of the public-private partnership stakeholders, has been included in clinical services since 2003. It is the first step in this respect worldwide. For example, public-private partnerships provide access to malaria vaccines in Africa, primary healthcare in Valencia, Spain, and cancer treatment in Germany. In 2011, Italy ranked third after Canada and the UK in the capital investment ranking in terms of realizing the projects with public-private partnerships in health services (Hamilton, Kachkynbaeva, Wachsmuth, & Masaki, 2012). Considering the public private partnership practices of other countries in the world; The reasons why stakeholders prefer public-private partnership in the provision of health services in Sindh province of Pakistan were evaluated as corruption in existing public hospitals, lack of responsibility in public services, poor inspections causing inefficiency, and public-private partnership arrangements providing better service delivery in existing primary health care units. In addition, it was stated that the main obstacle in front of public-private partnership practices is the resistance of health personnel (Khan & Puthussery, 2019).

Moreover, there are differences between countries in experience, use, and national government support for public-private partnerships. It is seen that professionals in Canada adopt the idea of performance-based management of the public-private

partnership, Dutch professionals value close cooperation with the private sector stakeholder, and Danish professionals attach more importance to the management freedom of the private sector stakeholder (Warsen, Greve, Klijn, Koppenjan, & Siemiatycki, 2020).

Turkey has also been experiencing the implementation of PPP like the other countries in the variety of areas. The significant area that the study concentrates is healthcare.

Table 4. Distribution of Project Numbers by Sectors in Turkey

Distribution of Project Numbers by Sectors	
SECTOR	NUMBER
Highway	42
Airlines	18
Marina and Tourism Facilities	18
Railway	1
Culture and Tourism Facilities	1
Customs Facilities	23
Industrial Facilities	2
Health Facilities	18
Energy	97
Port	23
Mining	8
Solid Waste	2

Source: Presidency of Republic of Turkey, Directorate of Strategy and Budget, The projects run by PPP's. Data accessed: 30.04.2021, retrieved from https://koi.sbb.gov.tr/

As the second phase of the Health Transformation Program, City Hospitals has been constructing throughout PPP. The Public-Private Partnership is mainly based on a long-term contractual relationship of the government with a group of companies as mentioned. The subject of the contract is the construction of the health facility to be provided with healthcare services by private companies and leased out to the

state. Thus, the scope of public service is also narrowed. The government is only responsible for core services at these facilities. The rest of the services are provided by the private sector and profit from it. The treasury lands on which the facilities are built are allocated free of charge. In other words, one of the partners, the state - so to say public budget which is collected by the citizens' tax -, pays the 'rent' to the other. Therefore, this situation should be considered as a resource transfer rather than a partnership. Besides, the scope of core service is so narrowed that the private activity in City Hospitals is too broad (Erbaş, 2021). It is seen that the primary goal of City Hospitals built with Public-Private Partnership is to make profit maximization, not provide to service in order to secure human health. This is because "commercial area revenues" such as medical support and support services in the hospital are left to private companies. Companies will be paid for all these, including the rental fee, for 25 years. Besides, a 70% bed occupancy rate guarantee is given to the companies that are won the tender. In other words, if the beds are not filled, payment will be made from the public budget for the bed that the 'customer' does not use. It clearly means that the citizens in the social state are being transformed as 'consumers' even in healthcare. A neoliberal citizenship regime is not a case in this thesis; however, it should be studied from the perspective of transforming citizenship. In addition to all these, despite the use of public resources, the details of the tender are not disclosed to the public on the grounds of 'trade secret' in Turkey. (Pala K. , 2018).

Within the City Hospitals context in Turkey, high costs are hidden, as IMF emphasized. In the case of Bilkent City Hospital, additional costs emerged from The Analysis of Value for Money stated by the Ministry of Health. In addition, the government assumes the exchange rate risk as the rental fees are based on the exchange rate. Therefore, it leads to increase costs even more in the long term (Pala K. , 2017).

City Hospitals are defended by public authorities as the increase of capacity of hospitals. However, for the construction and opening of the City Hospitals, the Public Hospitals have been closing. In other words, the capacity of hospitals and its number of beds has not been increasing in reality. According to the report belonging to 2U1K Engineering and Consultancy Company, in order to build two City Hospitals, Etlik and Bilkent City Hospitals, twelve Public Hospitals are planned to be closed. Six of them have been closed to 2021 just in Ankara (2U 1K Mühendislik ve Danışmanlık A.Ş., 2014). However, Turkey has been widely choosing to make Public-Private Partnership Contracts to construct City Hospitals.

4.4. THE BUILDING OF CITY HOSPITALS

The first regulation to allow public health facilities to be built for rental purposes is an article that is added to the Health Services Basic Law in 2005, enacted by the Motherland Party (ANAP) government in 1987. In addition, owing to the regulations in 2006 and 2013, the scope of the lease agreements was determined in detail. According to the regulations, the treasury land will be transferred free of charge to the companies that receive the tender. The building will be built for rent. Rent payments will also be covered by the revolving fund of the state hospitals that will be moved to the buildings. If the Revolving Fund cannot make payments, a treasury guarantee is given. The contract period is up to 49 years (Yılmaz, 2017). Besides, businesses which are worked and constructed under Public-Private Partnership contracts are also exempt from Stamp Duty.

Although comprehensive regulations such as the road to Public-Private Partnership regarding privatization took place during the Justice and Development Party, similar arrangements were also made during the previous coalition government consisting of the Democratic Left Party (DSP), Nationalist Movement Party (MHP), and Motherland Party (ANAP). The concept of privatization was entered

into the Turkish Constitution as an irticle title first time in this period that's why these regulations are actually prototypes of privatization (Erbaş, 2021).

Two constitutional amendments were discussed in the Grand National Assembly of Turkey in August 1999. One was related to human rights and the other was regarding preparing the infrastructure of the Public Private Partnership financing model. On 13 August, a four-item proposal package is approved by the overwhelming majority of the deputies in the Grand National Assembly of Turkey. The owners of the offers were Bulent Ecevit, Devlet Bahceli and Mesut Yilmaz. It shows that Turkish political actors coming from left to right were on the same page concerning privatization. (Erbaş, 2021)

The most significant point, in my opinion, is that these concession agreements are accepted to be subject to Private Law Provisions. Moreover, the way to international arbitration opens. More vividly, within this context, it should be noted that what dominates in case of disagreement is the contract itself, not the legislation in the Anglo-Saxon law. In other words, the ruler is only the contract (Çal, 2018). In addition to international arbitration, Article 3 of the Law No. 6639, which was accepted by the Turkish Grand National Assembly on March 27, 2015, has been replaced with the phrase “the case being heard in Turkey” has been removed from the text of the article. Thus, in case of any dispute, national court decisions that can protect the national interest are blocked.

Thus, the process of privatization and commercialization in health has started to gain momentum in the era of the Justice and Development Party which inherited regulations of a previous coalition government. First and foremost, JDP declared publicly Health Transformation Program after it won the general election, and immediately after, the tender of the city hospitals have started to make as the second phase of the program. In other words, It is a road to commercialization and

comprehensive privatization of health. The private actors starts enjoying profits in the field of healthcare.

Within this framework, private activity has been expanded from construction to business for the long term. The commercial area revenues in the city hospitals that are constructed by the private actors belong to the company. During the contract period, payments will be made to the companies as the utilization fees and service fees. The utilization fee includes maintenance/repair and rental fees. The service fee includes medical support services. It is expected that hospitals revolving funds will cover these costs, however, it is a question mark whether they can pay these costs. This is because the costs are very high. For example, a total of 3 billion 443 million TL will be paid for the Kayseri City Hospital in 25 years (Türk Tabipler Birliği , 2012). However, the tender for Erzurum City Hospital (1200 bed capacity) has ended with 193 million TL. The estimated cost is 260 million TL. In other words, Erzurum City Hospital with 1200 beds can be built with the 1.5-year rental price of Kayseri. In other words, It is seen that there is no classical and central tender method. This clearly shows the extent of the capital transfer and the inefficient use of public resources (Pala K. , 2018).

Another important issue regarding City Hospitals is the number of beds. The number of beds in hospitals is an important indicator of efficiency. In general, the number of beds is ideal in terms of efficiency between 100 and 600. The work of researchers such as Roh, Moon, and Jung shows that a 126 - 250 bed capacity is more efficient in the USA (Roh, Moon, & Jung, 2013). In Denmark, the most suitable bed capacity for public hospitals was found to be 275 (Kristensen, Olsen, Kilsmarkand, & Pedersen). These studies clearly show that the high number of beds in City Hospitals is an example of inefficiency. Besides, the Covid19 pandemic shows that it does not be suitable in terms of health, due to the fact that the crowd and bringing close together lead to increase infection risk. Therefore, the hospitals

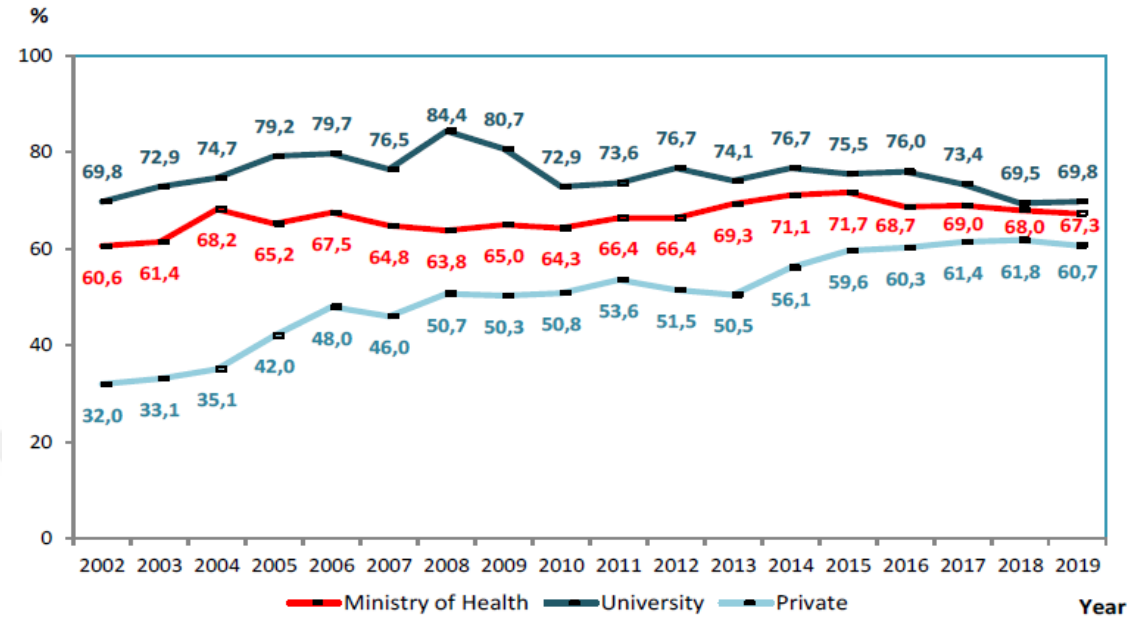
which were closed in order to be able to open the City Hospitals started to open again. For Example, Ankara Numune Hospital and Dışkapı Child Hospital have opened again after the pandemic.

Nevertheless, the indicator of efficiency is not only average bed capacity but also bed occupancy rate. The ideal proportion of utilization concerning bed capacity is regarded as 85%. The rate of utilization under 85% means that the number of beds is unnecessary. In other words, more clearly, it shows that cost of the hospital increases. The unnecessary capacity cost does not only contain the cost of an unnecessary number of beds but also includes the cost of closed space for beds, housekeeping of the closed space, and staff. It is not preferred that the rate of bed utilization is over 85% as well, due to the fact that empty beds have to be ready in the case of an emergency. Besides, the rate of bed utilization over 85% leads to an increase of infection. The Ministry of Health of the USA recommends that the proportion of bed occupancy is over %70. It mentions that if the rate is under %60, it means low efficiency (Marzieh Marahem, 2018). Succinctly, the rate of efficient capacity utilization ought to be 70% at least. Succinctly, the rate of efficient capacity utilization ought to be 70% at least. We do not know about bed occupancy in the city hospitals hitherto, however, we can know about bed occupancy in general in Turkey during the pandemic. According to the data of Minister of Health, Fahrettin Koca, the bed occupancy was %51 throughout Turkey in 2020 (Anadolu Ajansı, 2020). He actually shared to highlight that the bed occupancy is adequate to struggle against the Covid19. We do not know specifically the proportion contains to what extent the bed occupancy of the city hospitals. However, considering that the city hospital's occupancy across Turkey has an overwhelming number of beds, we can also depict that the city hospitals are inefficient in terms of bed occupancy.

Nevertheless, the indicator of efficiency is not only average bed capacity but also bed occupancy rate. The ideal proportion of utilization concerning bed capacity is regarded as 85%. The rate of utilization under 85% means that the number of beds is unnecessary. In other words, more clearly, it shows that cost of the hospital increases. The unnecessary capacity cost does not only contain the cost of an unnecessary number of beds but also includes the cost of closed space for beds, housekeeping of the closed space, and staff. It is not preferred that the rate of bed utilization is over 85% as well, due to the fact that empty beds have to be ready in the case of an emergency. Besides, the rate of bed utilization over 85% leads to an increase of infection. The Ministry of Health of the USA recommends that the proportion of bed occupancy is over %70. It mentions that if the rate is under %60, it means low efficiency (Marzieh Marahem, 2018). Succinctly, the rate of efficient capacity utilization ought to be 70% at least.

The rate of bed occupancy has already always been low in Turkey. In addition, even if the rate of bed occupancy in private hospitals in Turkey has been increasing in years, it has always been low in light of efficient beds occupancy. In other words, the beds in hospitals in Turkey are not using efficiently. The table belonging to the ministry of health proves it below. Ttbe datas below is up to 2019 due to the fact that the datas in 2020 and 2021 are not declared publicly.

Figure 4. Bed Occupancy Rates by Years and Sectors, (%)



Source: Republic of Turkey the Ministry of Health, Health Statistics Yearbook, 2019

Besides, the City Hospitals are included by the Ministry of Health, not Private Hospitals in the graph because the companies have been building them in the name of the Ministry of Health. This is because the private actors construct the city hospitals and borrow them in the name of the public. Therefore, it seems that bed occupancy is under 70% in City Hospitals as well. Besides, the details of contracts of City Hospitals do not declare publicly due to trade secrets and guarantee % 70-bed occupancy the contractor companies (Pala K. , 2018).Within this framework, in addition to taking a risk of high cost, the cost of unused bed occupancy will be paid to the contractor company, so to say that the cost hugely boosts. However, the private company does completely continue to earn more. In other words, health has been a lucrative instrument to accumulate capital thanks to City Hospitals.

Moreover, the contracts of the City Hospitals are signed over the dollar rate. In other words, an increase in the exchange rate leads to an increase in costs. For this

reason, the Ministry of Health has to make additional payments every year (Pala K. , 2018). It shows vividly that the debts will be increasing every year. The audit report of the Court of Account in September 2019 conveys that the public budget has been made a commitment by the administration for the sake of creditors. The Court of Account says clearly that the state budget regarding City Hospitals contracts has been shouldering the lion shares of the cost, what is more, this is unauthorized. Besides, the accounting records related to City Hospital contracts done by Public-Private Partnership cannot be reached. It means that the public interest has been eradicated evidently and it does not match transparency. (The Court of Account, 2019). Which areas the public budget and to what extend is used must be known by the people in a democratic society, because of the fact that the budget is collected by the money of the people.

The contracts of City Hospitals have been signing and they have been constructing since 2009. Thirteen City Hospitals have been completed to build and come into service in thirteen different cities across Turkey until today. These are respectively Adana City Hospital, Mersin City Hospital, Isparta City Hospital, Yozgat City Hospitals, Kayseri City Hospital, Manisa City Hospital, Elazığ City Hospital, Ankara Bilkent City Hospital, Eskişehir City Hospital, Bursa City Hospital, Istanbul Başakşehir Çam ve Sakura City Hospital, Konya Karatay City Hospital, Tekirdağ City Hospital. These City Hospitals have different bed capacities. The highest bed capacity is 3711 in Ankara Bilkent City Hospital. The lowest bed capacity is 475 in Yozgat City Hospital. Besides, it is expected that five more City Hospitals will be completing and coming into service by the end of 2021. These are Kocaeli City Hospital, Kütahya City Hospital, Ankara Etlik City Hospital, Gaziantep City Hospital and İzmir Bayraklı City Hospital. Considering the rising annual rent of City Hospitals and the total number of City Hospitals - 18 -, the financial burden is showing and will show an upward trend due to incentives and guarantees in the framework of Public-Private Partnership. Therefore, the number of new hospitals does not only represent abundance, wealth, and accomplishment

of the administration but also prompts a disproportionate amount of financial destroy.

In addition, each put into service City Hospital means that the new guarantees. In order to pay the guarantees, it is the potential of the close of public hospitals like in the example of Ankara. The fact that we do not know contracts' contents are supporting that argument. The City Hospitals are already not a public investment that is done by classical method. Therefore, the tangible situation that the public is renter cannot be regarded as a public investment.

Table 5. The City Hospitals in Turkey

No	The Project Name	Bed Capacity	Targeted Expiration Date
1	Adana City Hospital	1550	on service
2	Mersin City Hospital	1294	on service
3	Isparta City Hospital	755	on service
4	Yozgat City Hospital	475	on service
5	Kayseri City Hospital	1607	on service
6	Manisa City Hospital	558	on service
7	Elazığ City Hospital	1038	on service
8	Ankara Bilkent City Hospital	3711	on service
9	Eskişehir City Hospital	1081	on service
10	Bursa City Hospital	1355	on service
11	İstanbul Başakşehir Çam ve Sakura City Hospital	2682	on service
12	Konya Karatay City Hospital	1250	on service
13	Tekirdağ City Hospital	486	on service
14	Kocaeli City Hospital	1210	2021
15	Kütahya City Hospital	610	2021
16	Ankara Etlik City Hospital	3624	2021
17	Gaziantep City Hospital	1875	2021
18	İzmir Bayraklı City Hospital	2060	2021

Source: The Directorate General for Health Investments, The Ministry of Health, data accessed: 10.05.2021, retrieved from https://sygm.saglik.gov.tr/TR-33960/sehir-hastaneleri.html#

Even if the market activity has an increased level, it might not always present a threat to publicness. This is because the public purpose has been realizing. In other words, despite the fact that the market desires its own benefit, private institutions follow the public purpose and contribute to the public outcomes in that way. This is what another publicness is. At that point, the Turkish Healthcare System has significant and interesting content in the regulatory environment. This is because, while enforcing a comprehensive health insurance program which is included by Health Transformation Programme, private activity has been sharply going up. In other words, policymakers created a mixed provision for healthcare services, and thereupon, an internal market that is created works for its own profit maximization (Yılmaz: 2020). Thus, the capital transfer from the public budget to the market has been realized. Therefore, I evaluate that the city hospitals model is a significant part of the capital transfer. The public purpose still exists thematically, however, the organization which services provision and by this way keeps its benefits has been private companies. We can see in the interview of policymakers publicly. The discourse has been always based on the service that they do for the citizens. In reality, the fact is the money that the private companies have been earning is huge thanks to the Public-Private Partnership Model. This situation, at the same time, is called a 'hybrid system' (Yılmaz, 2020), and in the Turkish context, results in destroying social citizenship in the framework of the regulatory environment, because the understanding of public service has been drastically decreasing. I defend that invaluable things such as health must not be regarded as the subject of the market. I think that the acceleration always slips for the sake of the market as had been seeing hitherto. Briefly, private activity does not ally with welfare according to nature. At least, in the Turkish example, publicness environment and the balance of the focus between public and private has not been possible.

4.5. CONCLUSION

Healthcare is a huge sector and thereupon it attracts the attention of the capitalists in order to invest and accumulate capital. In this chapter, the healthcare sector including all components such as finance, labour-force and medication is explained.

Within this context, firstly financing of healthcare is focused. Financing of health services and the share of health expenditures in the level of economic development of countries are discussed in every country and are among the most important issues on the agenda of those who determine health policies. Whatever financing and delivery method it adopts, the main purpose should be the equitable and efficient delivery of health services in every country at an acceptable level of quality and access. For this reason, the increase in service use and health expenditures should not be considered as issues that should be put under pressure. However, if the increase in both issues occurs due to unnecessary use and inefficient use of resources, then the reimbursement mechanism has to take the necessary precautions for social benefit.

In this context, secondly, the Health Transformation Program in Turkey has been examined historically and economically. For this reason, it has been examined with all its developments. The Health Transformation Program includes a comprehensive neoliberal transformation from the delivery of health care to its finance. In this context, the main emphasis is that the health transformation program is the privatization of health.

On the contrary, Health Transformation Programme had, at the same time, led to the expansion the access to health because of the fact that it destroyed the four-layer health and social security system in Turkey, such as the Social Security Fund (SSK), The Social Security Organization for Artisans and Self-Employed (BAĞ-KUR), The Retirement Fund of Civil Servants (Emekli Sandığı) and Green Card for poor people. That fragmented structure regarding access to health is united by Justice and Development Party thanks to the Health Transformation Programme and it has given rise to an equal package to all citizens called Social Security Institute (SGK). Thus, all the people now have to register the system and pay premiums to the SGK. As a result, the overwhelming majority of Turkish people have been covered by public health insurance. The scope of the system increased, and thereupon the government attracted the political interest of the poor people in the 2000s. In addition, the program has brought about that public expenses increased. In other words public healthcare has expanded in an equal context (Dorlach, 2016).

Dichotomously and paralleled by it, private health financing has increased thanks to the increase in access to private health care providers, nevertheless, the scope regarding private health care is not equivalent for all citizens. The SGK does not pay for all services in private hospitals. So to say that the beneficiaries have to pay the extra money, named 'out of pocket'. In other words, getting higher quality health care service from private hospitals is based on to what extent having an income. It vividly means new inequality in health. In other words, despite the fact that the new system appeared by the Health Transformation Programme is more accessible than it used to, with the increase in the number of private hospitals, access to health has become to depend on the money that the people have. Within this context, Dorlach explains Dorlach explains that dualistic structure as a concept of ‘social neoliberalism’ (Dorlach, 2016). That is the point of success of Justice and Development Party in my opination. That is the point of success of Justice and Development Party in my opination. To be clear, on the one hand, the AKP governments have been drastically pursuing market-driven economy policy, on the

other hand, they have been pursuing an equalitarian policy in productive areas such as health, education and etc.

In addition to out of pocket with an increase in the proportion of private providers, the other most significant pillar of the changes in the financing of health services, City Patients, and its financing model was examined in the next chapters. The financing model of the City Hospitals is PPP.

Public-Private Partnership liquidates traditional public service production models where public project finance is financed from taxes and services are performed by public officials. It is based on establishing a long-term (up to 49 years) contractual relationship between the public and private sectors by linking public planning capabilities covering large-scale, integrated projects. It is an investment, service, and partnership system for the financing, construction, renewal, operation, and maintenance of infrastructure facilities and the provision of services. According to this system, hospitals that will provide public services will be built by private companies and leased to the state, and the state will both pay rent to companies and transfer services other than "core service" to be provided in this facility to these funds/companies.

The most striking aspect of the city hospital system is the high cost of hospital buildings and equipment to the public in terms of country resources. These operating companies, which have many privileges, will be exempt from VAT, stamp duty, and all fees. In other words, there will be tax loss as well as the rental obligation of the state. A full treasury guarantee is also given to the international loans that companies take from abroad for financing. That is, if the company does not pay its loan debt, the state "I will pay" gives a guarantee. The bill of approximately 45,000 beds, and therefore the disruptions in the system, will go to the treasury, that is, new costs and taxes will be imposed on the public. Ultimately, the public will pay the real high costs of city hospitals. The need for modern public

hospitals is an undeniable reality. However, there are serious concerns about the need analysis, demand and capacity planning while city hospitals are being implemented. The experience of city hospitals implemented in the UK and Canada in the past years has shown that such large hospital projects are both inefficient and difficult to manage. In many developed countries, this model has been abandoned (Pala K. , 2018). However, The City Hospitals which is made by Public-Private Partnership Model has been building and will continue to build in Turkey.

CHAPTER 5: CONCLUSION

The global capitalist order has been transforming since the late 1970s. The economic policies until that time had been mostly based upon productive industry, thereupon, the developmental state model was dominant. In other words; the composition of ruling class fractions was made up of industrial capitalists. In addition, in this process, owing to dominant Keynesian economic policies, social and economic rights had been dramatically gone up, such as union rights, high wages, the right to social security, and access to the right of health. Health was regarded as a state duty, both international contracts and domestic law were regulated according to this approach. All these developments influenced Turkey and the system of social security and health were organized in line with these developments. Turkey has also adopted Social Security System based on premium and Health System depending on strong state role aimed at comprehensive and accessible social policies. Socialization Project emerged at the beginning of the 1960s in healthcare, and then, health facilities were designed to become more accessible across Turkey, even if the project proved to be unsuccessful. Chapter 2 of the thesis has looked at the theoretical economic background and the relationship between health and economy within this context. This is because social security, a significant component of health rights, emerged in parallel with capitalist developments and demands.

Capitalist economy management based on the Welfare State, which is called the "Golden Age of Capitalism", tried to solve the economic crisis that started with the decline in profit rates with a new paradigm: Neoliberalism. In the 1970s, the liberalization process in the economy began not only in the early capitalist countries but also in the late capitalist countries. First of all, in this study, the historical and social background of the process in which the state acted in the political field

together with the capital fractions within the power bloc and integrated into the new paradigm in line with its capitalist interests was tried to be drawn. In the new alternative paradigm that capitalism produced in order to overcome the crisis, together with the notion of the relative autonomy of the capitalist state, finance capital as one of the class fractions in power, had the opportunity to find more room for maneuver and to organize its class interests in the power block. With neoliberalism, the borders of the states begin to be exploded economically. Therefore, mostly foreign finance capitalists have become new subjects of the power bloc. They are given a wide range of movement to foreign capital in domestic markets. In other words, the concept of 'continuous growth', on which the modern economy is based, manifests itself as financialization in the neoliberal form of capitalism. The Public-Private Partnership Model is the latest means of that financialization.

Turkey has also been integrating into neoliberal order since the 24 January Decisions in 1980. Within this context, Chapter 3 has explained that what economic context social policy emerged and how health policies developed historically in Turkey. At that point, there is barely social policy and healthcare services in the late Ottoman era and the early Turkish Republican period. Notably, after the 1930s, concrete steps were started to take by the policymakers regarding social rights and the healthcare system -notably health facilities. However, comprehensive healthcare services were started to be provided at the beginning of the 1960s, thanks to healthcare services socialization. All this period caters to the economy based on productive industry corresponding Keynesian economic policies. Nonetheless, the Keynesian capitalist order has started to create a profitability crisis in the late 1960s. Thus, the Neoliberal paradigm has started to play a critical role in the global economic order.

Within this context, neoliberalism that adopts a financial accumulation regime has been enforcing since the 1980s to create new financial instruments for the profit maximization of finance capital. The Public-Private Partnership Model is a significant instrument of them. It has been implementing in several ways and names across the earth. The City Hospital Model is the latest component of PPP in Turkey. Within this context, chapter 4 focused on the elements of the healthcare sector, health financing systems, the Private Partnership Model, and City Hospitals built by PPP in the healthcare area.

According to the definition and the implementations of the PPP that this study advocate, the contractor companies do primarily not aim to provide healthcare, desire to maximize their own benefits. The state role, which transformed to regulatory in the neoliberal order, enables them to do it thanks to the means of finance such as the PPP model.

In this process, private activity in health has been dramatically soaring for the last two decades. Private Hospitals have emerged and expanded as ‘ a new actor’ during the period of the Justice and Development Party, due to Health Transformation Programme in Turkey. The City Hospitals is also another alternative privatization, commodification commercialization way in healthcare, what’s more, it is not only commodification and privatization of health but also capital transfer from the state budget -financed by taxes of all citizens- to big capitalists (Yılmaz: 2017). This is because financial accumulation undoubtedly means, at the same time, to accumulate more owing to concessions, guarantees without having risk. Within the case of health, healthcare is also started to be financialized, as a part of being marketized, thanks to PPP. The capital transfer way is also mainly based upon loan contracts.

Borrowing has been a basic method of finance capital since neoliberalism emerged. Financialization has been penetrating the daily life of ordinary people for approximately twenty years in Turkey, after especially the 2001 economic crisis. Financial liberalization has not been enough to manage poorness and reach more growth rate. The solution is based upon that the flow of household income ought to be increased into the market. Therefore, getting credit and becoming indebted are the way of securitization. It is called 'financial inclusivity' (Güngen, 2021). City Hospitals that have been constructed by Public-Private Partnership Contracts are the other way of securitization based on debt for the sake of financial capital. In other words, The public sector has been becoming indebted and indebt reaches huge numbers. This framework has been realized thanks to the authoritarian neoliberal state form which is established in the 1980 coup d'etat in Turkey.

If the city hospitals that means a reflection of the financial accumulation in healthcare continue to be opened, more public hospitals including hospitals in small and rural areas might be closed in Turkey. There is uncertainty about what to do with the closed hospital buildings and lands. It has also stated that these buildings and lands might be transferred to the companies that received the tenders. Firms may establish new partnerships or use loans again for the reconstruction of such a new large complex. The construction of new facilities might not be only in healthcare. However, the public budget will continue to face drastic effects. Besides, when the interest expenses are included in the costs of the contractor companies, it is seen that the price that the state has to pay increases even more. It is seen that city hospitals aim to provide services focused on "profit", not "human health". The city hospital system, which benefits international financial institutions and companies, causes a long-term transfer of resources to global capital (Kumral, 2018).

Today, city hospitals are an example of an application in which the highest level of resource transfer to the capitalist class is made in the field of health and can be shown as one of the most striking examples of crone capitalism in the world. This model only works for the companies, because of the large shares transferred to the companies, the budget of the Ministry of Health is strained and in a sense, it is taken, hostage. This study defends equal access to healthcare and other social rights. The City Hospital Model depletes equal access, makes healthcare marketization. Furthermore, the Public-Private Partnership Model-driven finance eradicates the public budget. This is because the costs of City Hospitals have been increasing and will increase in the following years. Therefore, existing city hospitals should be expropriated without delay, and the construction of new hospitals by the public-private partnership method should be abandoned.

If the problem is that the private activity role in health boosts, why borrowing long terms are preferred? Moreover, it depends on long-term guarantee contracts. However, the entrepreneurs can invest in building their private hospitals according to the market rules. Therefore, the answer to this question cannot be only 'privatization' or 'commodification'. It is the capital transfer, including privatization.

In the City Hospital project, scattered health facilities are brought together. Thus, many areas such as urban planning, finance, public administration, and labor relations are affected by this implementation. The effect has already been achieved to some extent by the Public Hospitals Associations. Growth in scale also causes giant structures instead of “small and efficient management”; and whereupon a non-competitive, monopolized healthcare system emerges. Thus, hospitals are gathered under the management of several capital groups. This shows to whom the capital transfer highlighted above has flowed.

Besides, it is not possible to say that bureaucracy has decreased due to scale growth. On the contrary, a new risk of bureaucracy and inability to manage is emerging. In other words, the Ministry of Health is transforming into an administrative unit that concludes and monitors contracts, not providing services. However, considering the duration of the contracts, it is not possible to say that their management is easy. Apart from the length of time, the multiplicity of contracts to be signed between the administration and its contractors is another problem area. Managing these numerous, long-term and complex contracts requires a separate unit and specialized staff. Preparing and realizing tenders, preparing contracts, supervising their implementation, that is, contract management will constitute a separate cost item. Having a large number of contractors at the same time in a health campus is a requirement of this model. The resolution of disputes that may arise between companies (for example, a hotel provider and a parking lot operator, a healthcare provider and an operator providing medical imaging) is an important issue that will challenge the administration (Özer, 2014).

With the PPP, the public-private boundaries were blurred and the private sector entered into public services. Thus, the public becomes a mere observer role. This role means that the public withdraws from service provision in favor of the private sector. This is the fact in the neoliberal era that the liberal thinkers in the 19th century mentioned that 'Limited State'. In other words, neoliberalism is not new/neo.

To sum up, capitalism is restoring factory settings. The world experienced an interregnum period containing high social and economic rights until the 1980s. However, since the beginning of the 1990s, the Western-centered capitalist order has been sharply exacerbating social and economic rights thanks to a variety of its financial instruments and political regimes. The uncommercialized areas such as health care, too, are exposed to market attacks. City Hospitals are the latest market

attacks to access to healthcare services and rights to health in Turkey. The dissertation strongly advocates that healthcare is one of the invaluable human rights and it must not be a subject of financialization, marketization, and commodification.

I had to know my limits of mine in this study, due to the fact that it is an MA thesis. Therefore, the argument on the state was not a subject of the dissertation. In my opinion, the discussions concerning economy-politic transformations are generally examined depending on the political regime at least in Turkish literature. Nevertheless, there are a lot of studies on class inequalities or class theory in the context of the transformation of social and economic rights. However, the state theory is not being basically a subject of the studies.

I think that the analysis of class cannot be regarded without the state discussion, and whereupon, the social and economic changes cannot be understood without both of these debates themselves. Thus, the social struggle also cannot be done lack of these debates. The capitalist order across the earth in general, and the state mechanism, in particular, have been sharply transforming. There is no denying that a capitalist state purely is a class state as we have been facing hitherto and as the study occasionally mentioned. In other words, periodical changes of capitalism, and thereupon, of the classes have to also need the transformation of the state. The transformation is basically centered on cutting social welfare and wipe out a distribution that has been partly equal.

However, the most important transformation is the re-making of class power and re-production of the capital. In order to be able to achieve that, it needs a new economic accumulation regime. That accumulation regime makes even daily life financialization, as the study mention in a concept of financial inclusion. The neoliberal transformation owes its own success in that way.

Public-Private Partnership Models are a part of financialization and the new face of privatization in uncommercialized areas such as healthcare. Therefore, I hope that the thesis contributes and leads to debates on the state within the context of financialization.

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