

**Neoliberalization of The Health Transformation Program;
The Case of University Hospitals and Privately Owned Clinics
in Turkey**

Seda Zengin

110674007

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Yrd. Doç. Dr. Pınar Uyan Semerci

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Yrd. Doç. Dr. Pınar Uyan Semerci

Yrd. Doç. Dr. Şadan İnan Rüma

Öğr. Gör. Güney Çoban

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*For all the physicians and health
care labourers of this country...*

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Abstract

Turkey got involved in the neoliberal political wave, since 1980's. The Health Transformation Reformation has been a common interest of the changing governments since then. After 1990's the reformations in the field gained momentum, the government's responsibility to product health services turned into a responsibility to provide health services only and as the discourses like new governance and third way became spread; public-private partnerships, commercialisation and privatization showed a great increase. In this dissertation, the subtopics of the Health Transformation Program which was started by the JDP government under the name of "reform in the field of health" in 2003, General Health Insurance is discussed in the first place. Then, with the conducted interviews, the service qualities of university hospitals and privately owned medical centers are questioned by asking this in basic terms, "Did commodification of health services given in the hospitals improve the quality of them?". According to the results, the access to the health services got easy and as the statistics show, the access increased, whereas no improvements were experienced in the quality of services and on the contrary, a decline was witnessed. Moreover, an increase in the violence acts showed against the doctors and health care personnels was observed. These results form an image complitely antipodal to the one created in the public awareness by statements like "Every thing goes well in the field of health."

Keywords: neoliberal health policies; commodification of health care services; health care reforms; commercialization; privatization; university hospitals; medical centers; violence against health care labour force

Özet

Türkiye'nin de içine dahil olduğu neoliberal politika akımı, özellikle 1980'li yıllardan sonra, sağlıkta dönüşüm reformlarını, değişen hükümetlerin ortak ilgi alanı haline getirdi. 1990'lı yıllara gelindiğinde, yeni yönetim, üçüncü yol söylemleri yayıldıkça, kamu-özel sektör ortaklıkları, ticarileştirme ve özelleştirmeler, reform adıyla yapılan düzenlemelere büyük hız kazandırmış; devletin önceleri sağlık hizmeti üretme olan görevi, söz konusu yıllar içerisinde sağlık hizmeti sağlama görevine dönüştürülmüştür. Bu çalışmada, ilk olarak, AKP hükümetinin 2003 yılında ortaya çıkardığı Sağlıkta Dönüşüm Programı ve onun alt başlıklarından Genel Sağlık Sigortası ele alınmıştır. Daha sonra yapılan görüşmelerde, üniversite hastaneleri ve zincirleşmeye dahil olmayan özel tıp merkezi yetkililerine “sağlık hizmetindeki metalaşmanın hizmet kalitesini artırıp arttırmadığı” sorulmuştur. Görüşmelerden elde edilen sonuçlar ve başvuru alan diğer istatistiklere göre hastane servislerine erişim kolaylaşmış, artmıştır ve fakat servis kalitesinde olumlu bir değişim yaşanmadığı gibi aksine düşüş gözlemlenmiştir. Dahası, bu değişim, hekimler ve sağlık çalışanlarına karşı şiddet olaylarında artışa sebep olmuştur. Netice itibariyle bu çalışmada ortaya çıkan sonuç, “Sağlık alanında her şey iyiye gidiyor” gibi kamu bilincini etkileyen ifadelerle taban taban zıt bir görüntü oluşturmaktadır.

Anahtar Kelimeler: neoliberal sağlık politikaları; sağlık hizmetlerinde metalaşma; sağlık reformları; ticarileşme; özelleştirme; üniversite hastaneleri; tıp merkezleri; sağlık çalışanlarına karşı şiddet

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List of Abbreviations

BAĞ-KUR: Social Security Organization for Self-employed

GHI: General Health Insurance

HTP: The Health Transformation Program

JDP: Justice and Development Party

IMF: International Monetary Fund

IMKB: Istanbul Stock Exchange

MoH: Ministry of Health

PPP: public-private partnership

SPO: Ministry of Development and The State Planning Organization

SSK: Social Insurance Institution

SSI: Social Security Institution

TMA: Turkish Medical Association

WB: World Bank

UN: United Nations

THSK: Turkish Public Health Institute

Aim of the Study

Health is the main element of human life, community, society, and in a broad sense, nations overall. There must be a strong health care system for an advanced social security to exist which covers all the citizens of a country and this forms one of the main ideas of welfare state. Many of the developing countries have tried to set an acceptable health care system while developed countries have still been improving their systems in terms of adjusting different variables.

Turkey has been trying to find its own way also on the way of development as a developing country. For economic, social and environmental development; we know that there must be a strong and sustainable political will. In general, state plays a key role in many of welfare studies and Esping-Andersen's methodology of three welfare-state regimes takes the lead in this field. But it is hard to specify today's states in these regimes. Policies are shifting by adjusting globalization and so it is getting harder to characterize welfare states within these specific three types; liberal, social and conservative. Turkey is changing also and becoming more liberal in economic policies, less protectionist in social security and more conservative in social life.

This research mainly focuses on The Health Transformation Programme in Turkey which was set off by Ministry of Health in 2003 under the governance of JDP. It begins with a brief history of healthcare in Turkey, since 1980. Then, I aim to analyze the neo-liberal movements of The Health Transformation Programme in comparison between social state and social security ideology.

General Health Insurance (GHI), the case of university hospitals and privately owned clinics after the latest regulations will be the subheads of the survey. What makes this research different from the others is that there will be several interviews conducted with a group of people whose opinions were not taken in the process of The Health Transformation Program, inspite of being specialized in the health field, i.e. proffessor doctors, assistant doctors, executives from Turkish Medical Association and doctors with who own private clinics, along with the interviews with academicians who are related the field. JDP's neo-liberal health policies and its out comes to society will be researched while looking for a response to this question: Did commodification of health care services improve the quality of services?

Seda Zengin

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1. Introduction

Fundamentally social policies aim to meet human needs; e.g. education, health, housing and social security. To improve human welfare; different governments imply different forms of social policies with a set of ideas, goals, objectives, laws and operations. Main values in the field are equality and social justice which are the starting points of social policies.

Owing to the fact that governments play a key role in policy making, types of welfare states are also the determinants of the policies. It is obvious that in economic, social and environmental development there is a need to have a strong and sustainable political will. Today's welfare state regimes have been expanded, since Esping Andersen's methodology of three welfare regimes existed. Policies are shifting by adjusting globalization and so it is getting harder to characterize welfare states within those three specific types; i. e., liberal, social and conservative. By the globalization of the world, markets are interlinked locally, regionally and internationally even in the fields of industry or finance. Globalization is driving the changes in welfare states by adjusting them to the recent ways of economic growth. In that regard, Lister states in his book "Strong theories of the globalization, typically associate it with demise of nation-state and welfare state retrenchment." (Lister, 2010, p 21)

Polanyi's definition of the labour in market mechanism, can be shown as an example to the notion of commodification. Polanyi tells that market economy can only exist in market society. He states, labour, land and money, do not fall into the empirical definition of commodity because they are not produced to sell. But

the crucial point is that; even if labour is not a commodity, all the markets are still organised on the illusion that it is a meta. He further explains the fall of the market system which has made labour dependent on itself, through revealing the contradiction between the nature of man and the system. (Polanyi, 1944).

As Ayşe Buğra states, in fact, as the characteristics of market economy do not comply with the society, commodification of the labour can be stopped only by completion of civil rights, which provide security of an individual's life and property, with social rights. We see the reversal of this commodification process in the 20th century welfare state practices as a labour market defined by law again. Buğra claims that the development models applied in Turkey and Latin America are different than Esping Andersen's welfare state models, applied in the north. She differentiates the welfare state practice of Turkey because of the difficulty in the definition of a monotype state-individual relationship here. And according to her, it is because the unequal corporatist system which included the formal sector workers into the scope of insurance went into effect and it expanded by including some of the self-employed in time (Buğra, 2008).

On the other hand, according to Buğra, while EU membership played an important role in the process of shaping South European countries' social policies, in nonmember countries like Turkey, neoliberal globalization played different roles (Buğra, 2008). The divided social structure which was created by poverty whose shape was changed by the effect of migration and urbanisation, and by the unequal corporatist social security system, lost its sustainability in time.

Esping Andersen generalises the Southern Europe welfare models as underdeveloped corporatist examples, whereas Ferrera asserts that the socio-political course of action is completely different in those countries. The just social rights of Northern Europe countries, the strict, Weberian and just state concept there give place to a mellow state concept which is closed, particularist and based on the longstanding clientelism mentality in south¹. Ferrera, in general, explains the state of this conservative-corporatist continental model by the government agencies which are deficient in terms of professionalism and autonomy, ideologic polarisation and divided left in south; and the state of weak non-profit organisations by political parties which gained importance as the main actors (Buğra and Keyder, 2006).

From being a welfare state to becoming an employment state, the semantic shift experienced by the neoliberal dogma changed the relationship between the government and the individual also. As the state diminished and regressed, the responsibility was divided among the private sector which was put forward, non-profit organisations and governmental partnerships. This means precluding a civil right, a citizen's right to access to the health services, in a system left to the private sector. On the other side, mediatly, it means control of the employed labour force, the active labour market, like in the health field of Turkey in other words, by neoliberal policies.

Today, the concept of social security policies are also changing with regard to goals and financial means. Once it was written on Universal Declaration of

¹ This article is in the book Buğra, A. , Keyder Ç. , (2006) p 195-229, Ferrera, M. (1996) Sosyal Avrupa'da "Güney Avrupa Refah Modeli"

Human Rights: “Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.” (UN, 1948, 22) As a larger part of government expenditures in many countries, social security policies contain both economic and social goals. Considering that the objectives of the governments determine the social and economic policies, it will not be wrong to say that to achieve both of them in a world where welfare state retrenchment is increasing constantly is getting harder over time.

Considering Ferrera's works, Gough explains the four distinguishing qualities of Southern Europe social policies:

1-) “A double-income support system which provides high income support for the privileged groups, included in the formal labour force while provides low or irregular income support for the rest of the population. Moreover, inspite of the unemployment compensation provided to the individuals in the working age and families, along with the deficiency of the other supports, the generousness of the pension allowances is another inegalitarian side of the system.

2-) Still, health service systems are universal. As it is the case in such other services, also for these services, practices are far below than what is promised. Private sector, markets and privileges became integrated with public health services. There is always imrovidence and efficiency is low.

3-) As for the the planning and distribution of certain welfare services, particularism, clientelism and even poverty are frequently witnessed. Contrary to the Weberian bureaucracy model, as for politics, political parties which have deals for their own benefits are dominant.

4-) Dynamic transfer expenditures and difficulties, experienced in tax collection led to the "state's financial crisis". Southern Europe countries have the highest public debt ratio in proportion to GNP among all the European countries and it is esteemed that this ratio gap will increase gradually in the future (Buğra and Keyder, 2006) ².”

When we consider the historical process, we see that these four qualities cover the situation in Turkey mostly. Especially, considering public services which are planned according to the clientelism mentality, political parties which have relationships based on self interests for politics and the informal sector's existence which was overblown for years, along with corruption prove all these to be right.

The current discussions on social policy reforms are around the problematics of unsustainability and uneffectiveness of the systems under neo-liberal development strategies. Health as a component of social policy is inherently a hot topic to reform in many developing countries around the world. When it comes to integrated social assistance, for the countries with a rudimentary social assistance and a non-comprehensive social security net like Turkey and Southern Europe, it has always been easy to adopt health systems through the neo-liberal policies

² This article is in the book Buğra, A. , Keyder Ç. , (2006) , *Gough, I.*, “Güney Avrupa'da Sosyal Yardım”

(Gough, 1997). Likewise the discussion in Turkey, on the social security system reform has started firstly from the fiscal constraints of the social insurance institutions and then from the need of a health insurance with a basic coverage provided by the state.

Policies that are applied in the health field of Turkey today show us that the public's role in the field of health took yet another turn where it is redefined. The government started to play a more important role in financing and regulating of the health services, however, we see that it regressed from giving the service. The seperateness of the financing and the serving, hospitals which became autonomous and which are managed by professional executives, MoH whose duties are redefined and the responsibilities passed on some of the local authorities can be evaluated within this scope. Further, these policy changes in services brought a system where doctors and health care personnel are subjected to payments based on contract types and performance, prescriptions, number of tests and their referring authorities are controlled, followed and restricted. (Keyder, Ç. et. all, 2011) ³.

Before explaining the current situation of the health sector in Turkey, it will be helpful to give place to the hictorical development of the health policy and social security system. Speaking of the health reforms in Turkey, there are basically three main headlines; mandatory health insurance, pensions and social assistance. There will be a sum of health policy and social security system in Turkey.

³ This article is in the book: Keyder, Ç. , Üstündağ, N. , Ağartan, T. , Yoltar, Ç. (2011) p 37-54, Ağartan, T. , "Sağlıkta Reform Salgını"

Health and Social Security Policy in Turkey; Basics of the System

It is important to give some basic information about the history of social insurance system in Turkey. If we look at the Turkish Social Security System in general, there were three institutions until 2006; Pension Fund (1949), Social Insurance Institution (SSK-1945) and Social Security Organization for Self-employed (BAĞ-KUR- 1971). These three institutions were organized on the basis of labour force working area.

- Pension Fund was a retirement fund for civil servants and military personnel working in the public sector, providing social security for widows and orphans in case of death.
- SSK- Social Insurance Institution was the biggest institution for the general labour force which covers the %50 percentage of the population by providing health services and insurance.
- BAĞ-KUR- Social Security Organization for Self-employed was for self-employed citizens; artificers, artists and other freelance workers. This institution has also been providing insurance for housewives since 1979.

In 2000, the ratio of the population covered by social insurance programs was %68,2 and by the year 2009, it reached the %80,4 of the population. It shows us that there was an increase in the amount of the insured people but yet there were almost 1.5 million people out of scope. (Table1.1)

On the other hand, these social security institutions used to be separate and receive their insurance premiums on their own. While the Ministry of Finance

paid the wages of some personnels, working university hospitals, Ministry of Health also did the same for its own hospitals' personnel. Public hospitals used to have their own net current assets, besides their share from the general budget. However, after these institutions were gathered under SSI, the number of the contracted and subcontracted health workers, they employed, increased gradually. (Belek, 2012, p 50)

In 2006, these institutions were united under one institution which was named Social Security Institution (SSI-SGK) and got into force in 2008. The idea was simply that: to organize a sustainable social security system as described on the webpage of SSI: "...With this reform, insurance rights and commitments were equalized and foundation of a single financially sustainable retirement and health insurance system was prescribed... By the reform, it was also targeted to create equal, accessible and qualified health services of universal health insurance system for whole population." (The Legal Framework of Social Security System).

TABLE 1.1: THE POPULATION COVERED BY SOCIAL INSURANCE PROGRAMS										
INSTITUTIONS	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
I. THE PENSION FUND OF CIVIL SERVANTS IN TOTAL	7.372.907	7.645.117	8.062.947	8.244.950	8.349.458	8.448.727	8.583.980	8.722.348	8.867.512	9.028.211
Active Insurees	1.936.695	2.001.457	2.123.839	2.155.499	2.151.868	2.150.362	2.166.911	2.188.198	2.205.676	2.241.418
Pensioners	1.296.935	1.355.558	1.408.941	1.466.679	1.534.576	1.595.973	1.649.998	1.698.325	1.756.760	1.795.334
Dependants (1)	4.139.277	4.288.103	4.530.167	4.622.772	4.663.014	4.702.391	4.767.071	4.835.825	4.905.076	4.991.459
II. THE SOCIAL INSURANCE INSTITUTION IN TOTAL	22.741.166	22.358.590	23.768.525	25.072.673	26.718.480	29.104.207	30.884.857	32.498.087	33.330.984	34.264.467
Active Insurees	5.283.234	4.913.939	5.256.741	5.655.647	6.229.169	6.965.937	7.874.735	8.556.110	8.851.390	9.057.358
Voluntary Active Insurees	843.957	888.675	942.024	697.630	327.962	266.558	271.369	269.075	256.097	52.116
Active Insurees in Agriculture	184.675	142.306	149.163	165.268	176.717	178.178	187.951	215.340	218.094	191.800
Pensioners	3.339.327	3.560.638	3.747.573	3.935.523	4.120.866	4.308.186	4.510.701	4.763.434	5.024.696	5.290.415
Dependants (1)	13.089.973	12.853.032	13.673.024	14.618.605	15.863.766	17.385.348	18.040.101	18.694.128	18.980.707	19.672.778
III. THE SOCIAL SECURITY INSTITUTION OF CRAFTSMEN, TRADESMEN AND OTHER SELF-EMPLOYED IN TOTAL	13.687.447	13.916.084	13.947.593	14.249.370	14.550.239	14.290.187	14.651.880	14.734.569	14.567.448	14.705.935
Active Insurees	2.220.014	2.198.200	2.192.555	2.268.971	2.212.299	2.103.651	2.082.318	2.052.584	1.897.906	1.832.133
Voluntary Active Insurees	216.532	249.306	237.801	191.644	238.313	239.388	244.105	243.931	235.069	389.791
Active Insurees in Agriculture	876.148	889.149	890.976	923.234	997.937	1.011.333	1.049.206	1.079.785	1.127.744	1.014.948
Pensioners	1.277.444	1.343.840	1.393.670	1.445.820	1.519.190	1.600.294	1.753.025	1.817.685	1.965.247	2.088.146
Dependants (1)	9.097.309	9.235.589	9.232.591	9.419.701	9.582.500	9.335.521	9.523.226	9.540.584	9.341.482	9.380.917
IV. THE PRIVATE FUNDS IN TOTAL	306.766	323.569	324.302	295.541	301.441	307.161	298.269	310.850	323.218	331.205
Active Insurees	118.485	78.495	71.641	70.925	73.412	75.685	85.358	95.341	105.707	109.668
Pensioners	59.940	71.266	77.738	71.595	74.367	76.027	78.082	79.388	81.042	82.459
Dependants (1)	128.341	173.808	174.923	153.021	153.662	155.449	134.829	136.121	136.469	139.078
V. GENERAL TOTAL	44.108.286	44.243.361	46.103.368	47.862.535	49.919.617	52.150.282	54.418.986	56.265.855	57.089.162	58.329.818
Active Insurees	9.558.428	9.192.091	9.644.776	10.151.042	10.666.748	11.295.635	12.209.322	12.892.233	13.060.679	13.240.577
Voluntary Active Insurees	1.060.489	1.137.981	1.179.825	889.274	566.275	505.946	515.474	513.006	491.166	441.907
Active Insurees in Agriculture	1.060.823	1.031.455	1.040.139	1.088.502	1.174.654	1.189.511	1.237.157	1.295.125	1.345.838	1.206.748
Total Active Insurees	11.679.740	11.361.527	11.864.740	12.128.818	12.407.677	12.991.092	13.961.953	14.700.364	14.897.683	14.889.232
Pensioners	5.973.646	6.331.302	6.627.922	6.919.617	7.248.999	7.580.480	7.991.806	8.358.832	8.827.745	9.256.354
Dependants (1)	26.454.900	26.550.532	27.610.706	28.814.100	30.262.942	31.578.710	32.465.227	33.206.658	33.363.734	34.184.232
VI. RATIO OF INSURED POPULATION (Percent)	68,2	67,9	69,8	71,6	73,7	76,0	78,4	79,7	79,8	80,4
VII. TOTAL POPULATION	64.695.517	65.135.000	66.009.000	66.873.000	67.734.000	68.582.000	69.421.000	70.586.256	71.517.100	72.561.312
SOURCE: T.R. MINISTRY OF DEVELOPMENT, ECONOMIC AND SOCIAL INDICATORS (1950- 2010)										
(1) Estimate										

After, Social Security Institutions' hospitals are transferred totally to the Ministry of Health under the financial control of SSI. These institutions which have originally emerged for the labour class' insurance needs, has been autonomously financed with insurance charges and with this transfer of control, the authority directly passed on to the government. Due to of the institutions' budget deficit problems, they have all been perceived as useless and instead of trying to create solution oriented formulas, these institutions are transferred directly to the government. So in this new structure, SSI became a monopoly in terms of regulating health market. The government's neo-liberal health policies have also created an awareness in the labour unions. Even though there has been a considerable public awareness concerning this decree laws, eventually this was not enough.

With these instructions, it is obvious that there is a need for a system which is financially well organized and covers all the citizens on equal terms by the cooperation of different institutions in the field. But in practise, from the beginning of the health reform there has been an obvious lack of coordination between ministry of health, social security institution, university hospitals, institutional hospitals and Turkish Medical Association (TMA) which has the real authorities to make decisions in the field. The main challenge is trying to manage these institutions with different structures through a centralized governance, such as The Ministry of Health. Due to the health systems' multidimensional structure, it has been more difficult to plan and organize all of the mentioned institutions in the field (Soyer, 2007). These issues cause reduction in the quality of health services, especially in university hospitals which will be the subject of third

chapter. So the programme must be also locally adaptable for different requirements of different health institutions.

On the other side, starting point of social security institutions was to fight against poverty during post-war times and to provide an acceptable insurance for labour class. Through this approach, for the first time; a universal model was provided solely by the state in the history of Turkey. This is a milestone in the history of Turkish Social Policy; The Decree of 1961 Socialization on Health Services which was made with the aim of socialization in social security and health services. In the early stages of the development, especially preventive health care services both in rural or urban areas were put into rule. With this objective, The Socialization Department was established within the Ministry of Health and operated for 23 years. After several years of development policy programmes, this decree expired.

By The Decrees of 24 January 1980, an economic recovery program was initiated by Turgut Özal, undersecretary of the prime ministry, with a primary importance of liberated policies and foreign capital investments. On behalf of structural adjustment, the direction of economic policies shifted from import-substitution policies to export- oriented policies under the military regime. (Boratav, 2008). 1980's were the years of first generation structural adjustment reforms under the supervision of IMF, in all developing world. Outward-oriented economic growth and financial liberalization policies which were originated by a huge international capital hegemony, later would end up with a set of hyperinflation, budget deficits and so financial crisis in developing world like

Latin America and Asia. The changes on international capital interests have directly affected production processes and types; therefore they changed legal and administrative rights of labour power in Turkey negatively. In the following years of deregulation for international financial capital, even if capitalism had numerous economic and financial crisis in all around the world, economic growth would be the unique objective of governments and the next center of attention of capital investments would be the public services.

Before, it was a provider of health services, government became a controller in health by the Constitution of 1982, with this article; “...Government is responsible for everyone’s lives with ensuring their own continued physical and mental health; by enhancing efficiency in human and material power, it aims cooperating in health services via central planning and services. Government tasks this duty by taking the advantage of public and private sectors’ health services and with controlling them. A general health insurance can be applied to universalize the health services (Article 56: Health Services and Environmental Protection).” The field was left clear with this article for the liberalization in all part of health institutions, health labour power and infrastructural investments.

As objectified in 1980’s, liberalization accelerated and deepened in health and education at the same time with a high promotion of WB projects and IMF in 1990’s (Labonté, 2011). Within that decade, commercialization in health became prominent, especially on privatization on health institutions. In 1998, IMF’s Staff-Monitoring Agreement for Turkey was signed and it became a turning point in the history with improvements such as 1980 decrees. The agreement, placed Turkey

into a different position where the economic, political and social policies of country were directly under the control of IMF, WB and international financial credit rating agencies. In other words; Turkey accepted to be dominated by these institutions' neoliberal policies through this agreement. For example, IMF declared various requisitions from Turkey: the most relevant one to our subject was commercialization of social security services which would transform citizens-public services relation to a customer- salesman type of commitment.⁴

Afterwards, the “good governance discourse” which equals to democracy and economic liberalism for a successful economic development, was spreaded to the development agendas by World Bank. Next, the notion of “efficiency and quality in public services” ,which took on a new significance, particularly in the health sector in Turkey, was stated for the first time in the Sixth Development Program (1990-1994). “Good governance rhetoric was pointing out effective and democratic governance that was in fact to provide public support in the reconstruction of neo-liberal understanding while taking strategic, economic and political decisions out of the control and implementation mechanisms of the democracy” (Independent Social Scientists’ Alliance of Turkey, 2006, pg. 4). According to this statement, government was considered as a provider of preventive healthcare services and in the medical and rehabilitative services government would leave the field to the private sector and act as a controller only. It was also declared in Seventh Development Program (1996-2000) that “hospitals were not efficient due to not being open to competition and absence of a modern structure which was self-sufficient and autonomous in managing and finance”. (SPO, 1996, 14) This

⁴ For more information; Independent Social Scientists’ Alliance of Turkey, 2006

objective was including the keywords of a new discourse in that era: The New Public Management. Once, it was the producer of public services, however, by the PPP public-private partnerships in the investment fields, state would become the provider of public services.

2. The Health Transformation Program; From Beginning to the Current Situation; The Case of University Hospitals and Privately Owned Clinics

Introduction:

This section of the thesis covers the discussion on the effects of the HTP implementations firstly, as to the university hospitals and secondly, in general the medical centers which do not participate in the private hospital chains. I took into consideration that the facilities and the personnel I interviewed would not only be professionals but professionals that are excluded from the reform process. With this sampling plan, I aimed to analyze the data I've acquired from the interviewers and tried to generalize and feed these into the research. It should be mentioned here that as Punch and Babbie have stated; it would be erroneous to extend my findings acquired from my samples to the general population (Punch 2005, Babbie 2010). From this perspective, the results acquired should be attributed to the general health sector and not to other domains.

Three major university hospitals of Istanbul and three medical centers from different districts of Istanbul, placed in Beyoğlu, Halıcıoğlu and Büyükçekmece are subject to the research. Again, for the same purpose, interviews were conducted with people from different fields of the health system, i.e. primary care physicians, specialists, academician doctors, resident physicians and new graduate medical students. In addition, there were also executives from İstanbul Medical Chamber, who are closely related to the issue and academicians, whose professional fields cover social politics too, among the interviewers.

All of these were in depth interviews, conducted face to face. The names of the interviewers and the titles of establishments are kept confidential as the research requires. On the other hand, these interviews were answered mostly with in-depth commentaries rather than being a questionnaire type of survey.

The interviews were generally conducted after working hours of doctors and in their offices. The interviewed professors and academicians were chosen, as they are professionals in the researched field or they have works in the field. In general, the interviews were conducted by both audio records and taking notes. After the aim and scope of the survey were explained to the interviewers, they were asked for their informations, experiences and opinions within the context of questions, listed below.

Interview Questions;

1. What are the advantages and disadvantages of the health transformation program? What do you think?
2. How did the changes in university hospitals' service quality turn out to be? Good or bad? If so, how?
3. Did the access to health services get easy?
4. How did the given performance criterias effect the health services? How do you review the increase of the surgeries and the medicine consumption?
5. It is said that there is an increase on the rates of violence against doctors and health care personnel, what do you think about it?

6. What do you think about the economic downfall of publicly owned university hospitals and their bounding to the Ministry of Health? How did all these effect the university hospitals in terms of science?
7. Where do you see publicly owned university hospitals in the near future? What awaits medical students in terms of education?
8. There is a rapid increase in the number of the medical faculties established in private/foundation universities. How do you evaluate the education given in these schools and their health services?
9. What is your opinion about the project of integrated health campusses?
10. What is your opinion about the privately owned clinics which stay out of private hospital chains?
11. Finally, is there anything you would like to add or share? A memory, an advice or anything that you think will contribute to the work?

As I choosed to ask open ended questions, I aimed to have more comments by the interviewers rather than yes/no answers. This caused me to have longer interviews than expected sometimes and thus, harder conversations to study after. However, I should state that my aim in this field research, as it can be understood by the number of the interviews, was to state the opinios of the professionals in the field rather than having statistical results. In terms of this, I can say that it was the correct desicion to prepare the questions in this way.

As the interviewers were chosen from five different labour force of the health sector, it served the purpose and helped us to view the situation from different perspectives. Along all this field research process, I had the chance to benefit from the knowledge and experiences of all the interviewed professors, doctors and specialists. I should also state that in the following sections, all the interviews I quoted directly were formed by the audio recordings and the notes I took during the interviews. In that respect, it should not be regarded as a classic litterateur source. You can see the number and classification of the interviewers in Table 2.1.

Table 2.1: Numbers and Classification of Interviewers

Classification of Interviewers	Number
Professors in University Hospitals	4
New Graduated Medical Students	3
Assitant Doctors in University Hospitals	2
Executives of İstanbul Medical Chamber	2
Doctors who own clinics	3
Academicians in the field	2
Total:	16

2.1. Evaluation of The Objectives of Health Transformation Program; Efficiency, Productivity and Equity

Ministry of Health has declared The Health Transformation Program in 2003 first as a proposal. The framework of the program has prepared with the receipts of International Monetary Fund which were actually requirements for the 8. stand-by agreement. With the guide of World Bank professionals, framework has become an actual program and come into force in 2004. The emergence of the program was with similar title among its kind; a universal health insurance which covers everyone. In a modern, global world where the economic crises happen one after another, the rise in the unemployment rates and poverty are typical events in many of developing/developed countries, it is clear that there has to be a social security system to secure all citizens against these threats which is the main principle of social state mentality. However, from the beginning of it “efficiency and productivity” criterias on new health system showed that program was serving for neoliberal health policies, that are still effective all over the world. This means that state was moving away from social state ideology with shifting policies to neoliberal forms.

The objectives of the program are described as below in the framework: to organize, to provide financing and to deliver the health services in an effective, productive and equal way.

”Efficiency means the aim of improving the health level of our public through effective policies. The main target in the delivery of the health service must be the prevention of people from the diseases instead of the treatment of the patient. Attaining this objective will be possible with the advances in the

epidemiologic indicators. A decrease in the maternal and child mortality and morbidity ratios and an increase in the life expectancy at birth will be the most concrete proofs of the above mentioned objectives.

Productivity is the proper use of the resources by reducing the cost and producing more services with the same resources. Distribution of the human resources, management of materials, rational drug use, health administration and preventive medicine practices should be evaluated under the framework of this goal. Involvement of all sectoral resources of the country in the system and achievement of integration will enhance productivity.

Equity is the achievement of the access of all citizens in Turkey to health services and their contribution to the finance of the services on the extent of their financial power. The scope of equity includes decreasing the gaps concerning access to health services and health indicators among different social groups, between rural and urban areas and between east and west. ” (The Health Transformation Program, 2003, p.24-25)

Regarding productivity and efficiency objectives; even if the main focus was on the health services productivity, it was seen that the health system was considered as a market. The notion of efficiency, here stands for cost efficiency, which is found nearly in all of the capitalist systems, as also Lister states it, rather than rendering of the health services in the quickest and most effective way (Lister, 2008, 169-70). And that means, the objectives of the program are linked directly to the commodification of health services. In this respect, comparing the 2nd step public health institutions with the 2nd step private health

institutions like medical centers and branch hospitals which give the same services, in terms of the average costs per patients, we see that the private section serves for higher prices. As a matter of fact, SSI payments, made to private hospitals increased.⁵

In the equity objective, there was a contradiction within the statements themselves. It was stated that citizens can access the health services as long as they have the financial means. In a system where the health services provided to citizens depend on their financial power, it is not possible to decrease the gap between the poor and the rich. This shows us the main contradiction of The Health Transformation Program.

With regard to this, an academician we interviewed stated, “ There is a great deal of trading between the local and the foreign capitals. As there is such a big flow of the private capital to the health field, the relation of the public to health services has changed. In our day, the government leaves most of the field to the private sector promptly, and in the rest of the field, prefers to profit from its services by cost minimization and performance analysis. The aim of productivity and efficiency, stated in every text of HTP affirms that (see Appendix C-2).”

⁵ Independent Social Scientists’ Alliance of Turkey, 2011, p 206-7

2.2 A New Model to Finance Health Care Services: General Health Insurance

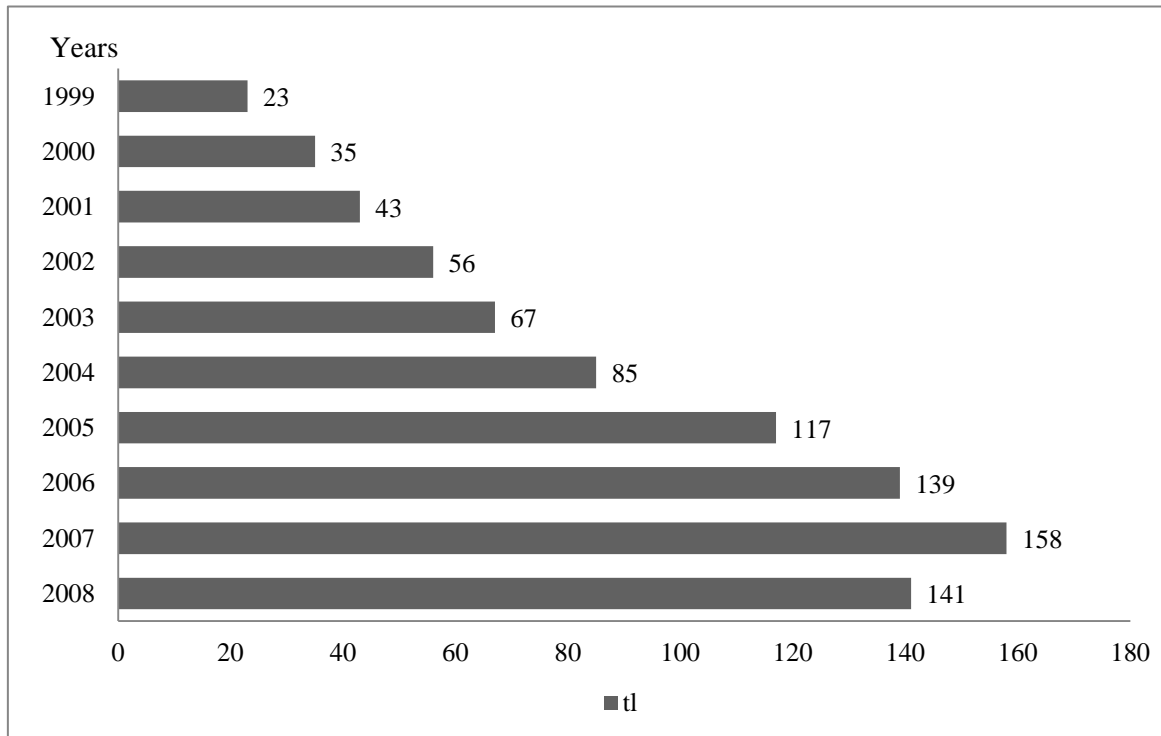
General Health Insurance (GHI) covers everybody in the society and provides them minimum standards of health services. On account of this idea in the framework, it is stated that: “In addition to setting up General Health Insurance System, establishment of private health insurance will be supported and the existent private health insurance within the system will be provided by with a complementary role. Further to guarantee package included by Mandatory General Health Insurance, the people that demand service can be covered under private insurance and can demand their services through these companies. Thus, private insurance will be encouraged.” (The Health Transformation Program, 2003, p. 28)

Social Insurance and General Health Insurance Laws were accepted within the objectives listed above in 2006 (Republic of Turkey Prime Ministry, 2006). But they went in effect, only after the constitutional court's significant cancelment desicions, which did not happen until 2008. All the pension and health financing models were changed with this law, on the grounds that financial sustainability could not be achived with the current social security and health systems.

Although GHI, as a new financing model of health services in Turkey, is thought to be a public insurance model at the first sight, it turns out to be a combined system, if you consider participation fees, patient shares and the differential fees, charged by hospitals (Belek, 2012, p 79- 80). As a matter of fact, out-of-pocket expenditures of health were low before practices of JDP’s health

policies; however, they increased rapidly over the following years. (see Figure: 1.1)

Figure 1.1 Per Capita Out of Pocket Expenditures by Years, in TL, Turkey



*Source: The Ministry of Health of Turkey, Health Statistics Yearbook 2010, Refik Saydam Hygiene Center
Presidency School of Public Health*

In this respect, one of the academicians stated that; ” In fact, the increase in the number of the people covered by GHI is the demand, created to meet the supply of health services, which is commodified while it grows constantly”(see Appendix C-2). However, all the interviewers agreed on that the coverage expansion of GHI did not bring any enhancement in the service quality.

On the other hand, Ministry of Health delegated the authority for 1st step health services, including the community health centers and the family doctor system to Turkish Public Health Institute, called THSK by the Decree Law No. 663, dated 2 November 2011.⁶ The Executives from TMA, said that this situation will trouble the preventive health care services which are considered to be backbone of the system.

As a matter of fact, the current service units like General Directorate of Mother-Child Health and Family Planning, Department of Malaria Control, Department of Tuberculosis Control, Department of Cancer Control are not included in the new organization chart. Specialists consider the Family Doctor System as the privatization of the 1st step health services, as it happens to be a system in which the medical staff will work under contract, without job security, the preventive health care service will lose its integrity, only therapeutic health services will have importance and the risk groups' (aged, poor or disabled people, along with women, children and people with chronic diseases) access to health services will be hindered actually.

Besides these, government health expenditure is another important subject that we should dwell on. During the rule of JDP, there has been a great increase in government health expenditures. The incentives for the private sector, coming as a subtitle of the transformation in the health field are significant as to that. As the government started to get service from the private sector, the private sector investments to the health field were promoted. It would be wrong to say that

⁶ Resmi Gazete, 663 nolu khk;
<http://www.resmigazete.gov.tr/main.aspx?home=http://www.resmigazete.gov.tr/eskiler/2011/11/20111102m1.htm&main=http://www.resmigazete.gov.tr/eskiler/2011/11/20111102m1.htm>

there is only one way of privatization. In Turkey, the current case is that the government buys the service, it used to produce itself, from the private sector, which can be called as the hidden private in public health services. The government prefers not to produce these public health services any longer but to buy them from the private sector. By like tendering, granting privilege and chartering public-private partnership has improved significantly (Davas, 2011).

In 2008, health expenditures in Turkey reached to 57.740.000 TL in total (TUIK, 2012). While %61,1 of the total health expenditures were made by the government in 1999, the percentage increased to %73 by 2008 (see Table 2.2). All these highly contradict with the concept of minimal state and the reduction of government health expenditures that the state of JDP mentioned from the very beginning.

On the other hand, the scope of GHI was reduced due to the fund shortage. Every year, which health services GHI will cover is defined by the minimum liability insurance. In our day, a patient with GHI, pays high contribution fees for medicine charges, dental treatments or eyeglass prescriptions. The ones who want to benefit from health services which are out of GHI scope are directed to the private health insurance companies by the Supplemental Health Insurance.⁷

⁷ HASUDER TÜRKİYE RAPORU 2012, TÜRKİYE’DE SAĞLIK POLİTİKALARI VE İSTİHDAM içinde IV-SAĞLIK FİNANSMANI (Doç. Dr. Bülent Kılıç)
http://hasuder.org.tr/anasayfa/images/stories/dosyalar/salk_politikalar_1.pdf
http://www.nilufer.bel.tr/alt/pdf_doc/saglik_reformu.pdf Kayıhan Pala

Table 2.2: Health Expenditures in Turkey, 1999-2008 (million TL)

		General Government			Private Sector		
Years	General Total	Total	Central+ Local Government	Social Security	Total	Household	Other ¹
1999	4.985	3.048	1.432	1.616	1.937	1.449	488
2000	8.248	5.190	2.304	2.886	3.058	2.280	778
2001	12.396	8.438	3.843	4.595	3.958	2.832	1.126
2002	18.774	13.270	5.639	7.631	5.504	3.725	1.779
2003	24.279	17.462	6.800	10.662	6.817	4.482	2.335
2004	30.021	21.389	8.159	13.231	8.632	5.775	2.856
2005	35.359	23.987	9.987	14.000	11.372	8.049	3.323
2006	44.069	30.116	12.449	17.667	13.953	9.684	4.269
2007	50.904	34.530	14.883	19.697	16.374	11.105	5.269
2008	57.740	42.159	16.813	25.346	15.580	10.036	5.545
Percentage %							
1999	100	61,1	28,7	32,4	38,9	29,1	9,8
2000	100	62,9	27,9	35,0	37,1	27,6	9,4
2001	100	68,1	31,0	37,1	31,9	22,8	9,1
2002	100	70,7	30,0	40,6	29,3	19,8	9,5
2003	100	71,9	28,0	43,9	28,1	18,5	9,6
2004	100	71,2	27,2	44,1	28,8	19,2	9,5
2005	100	67,8	28,2	39,6	32,2	22,8	9,4
2006	100	68,3	28,2	40,1	31,7	22,0	9,7
2007	100	67,8	29,1	38,7	32,2	21,8	10,4
2008	100	73,0	29,1	43,9	27,0	17,4	9,6

'(1) "Other" health expenditures cover health expenditures of private social insurance schemes(bank funds), non-profit organizations serving households, state economic enterprises, foundation-owned universities, intuitions covered by privatization and all other enterprises.

Source: TUIK, Health Expenditures

Today, by the proposed law of integrated health campuses whose tenders are still continuing, roundly 900 public hospitals bound to MoH are intended to be united in their cities or nearby cities (TTB, 2007). Planned to be autonomous establishments which have public entities and to be open to privatization in the

future, to whom these campuses will serve is a problematic and doubtful question. As this will also result in the privatization of the public hospitals, low income groups will be eliminated as to the access to the health services which are out of GHI's scope.⁸ It will be useful to quote one of the interviewed academicians' opinion about the subject:

“Integrated health campuses will be based on the private sector management mentality, though the medical personnel will be provided by the government. These campuses are established by various tenders of the private sector. Let's say, a physical medicine service will be established in this campus and let's say that we need a field of 25 square meters at least, when we consider the issue medically; nonetheless, it would be regarded as too much, when considered in terms of commerce and there would be restrictions, probably. And this may cause medical and ethical problems... When public hospitals are reduced to campuses, the nearby public hospitals are most likely to be closed and be integrated to these campuses. Thus, the nearby citizens will have to go to these integrated facilities to have the service. And also, we do not know how much the additional fees, charged by these campuses, will be. It is hard to foresee, but inevitably, we think that the situation evolves to a commoditisation process (see Appendix C-1).”

As for the subject again, an executive of TMA told us, *“As for the integrated health campuses, their buildings and managements are said to be publicly owned however all of their staff or executives are not public employees and even, they do not need to be related to the health sector to work there. The managers will consider accounting records only and pay attention to profitable departments. Ankara Etlik Hospital went out to auction by 2.3 quadrillion Liras as the so called integrated health campuses would be established. However, these hospitals will be built by the private sector and their management will belong to the private sector for 25 years and Ministry of Health will provide only doctors and nurses for these. In fact, they are said to be formed by the public and private sectors' partnership, however these will be facilities taking*

⁸ http://www.ttb.org.tr/kutuphane/kamu_hastane.pdf KHB yasa tasarısı üzerine değerlendirme

most of their services like automation, parking and laundry from the private sector. Thus, I can not even foresee the prices that await for the patients applying to these. I would not like to say this, but, when even the public hospitals are turned into these campuses, it seems like people will long for the current system in the future (see Appendix B-1). ”

Though the management seems to belong to the government, considering that the buildings, the given services and even the personnel will be provided by the private sector, it is uncertain for whom these integrated health campuses will serve. The annual rental payment, the government will make for the Ankara-Etlik auction alone is 289 million TL. Even this auction alone would be enough to cause the government to make loss, however if you consider that there are 45 projects like this in total, the seriousness of the case reveals itself. If we think of the recently rising health tourism and the expressions like "Hospitals in the comfort of a five-star hotel", we can see that all these pose danger to the public health in fact. Turkish Medical Association took action on the grounds that the regulation was against the constitution, thus the Council of State decided to stop the implementation of the regulation for now.⁹

⁹ <http://www.ttb.org.tr/index.php/Haberler/kampus-3268.html> KHB yürütmeyi durdurma kararı

2.3 The Case of University Hospitals After The Latest Regulations of HTP

University hospitals, being 3rd step health facilities, play an important role in Turkey's health system.¹⁰ Since these are not profit oriented enterprises, they can not be evaluated in terms of profit and loss accounts or cost analyses. As the primary aim of university hospitals has always been education in the first place, their object to provide health services comes secondarily, after that.

In 2011, academic members of university hospitals were prohibited from working free lance after finishing up their work in these hospitals by the Decree Law No. 650, which is also known to be the full-day law.¹¹ According to the sub clause added to the Law No. 36, doctors who work in state institutions and organizations were only allowed to work in public sector.

Hence, the academic members who work free lance after the end of their business days in university hospitals were put in such a situation that they could not examine or treat patients there any longer. University hospitals could not take care of the medical cases, which require special expertise and that affected both the low income patients and the medical education and research, given in these faculties negatively. Nonetheless, academic members opposed to that and they brought an action against the regulation, thanks to that, most of the regulations evolving doctors were revoked by the decision of the constitutional court on 20 July 2012. Nevertheless, academic members who preferred to work

¹⁰ SUT, Sağlıkta Uygulama Tebliği, Notice of Health Practices

<http://www.mevzuat.gov.tr/Metin.Aspx?MevzuatKod=9.5.13891&sourceXmlSearch=&MevzuatIliski=0>

¹¹ TTB Hekimler ve Tabip Odası Yöneticileri için Mevzuat;

http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=887:yen-tam-guen-yasasi&catid=1:yasa&Itemid=28

in the private sector and left the public university hospitals beforehand caused a significant blood letting in these faculties. One of the interviewers who was an academician stated that that had caused %40 of the faculty members to be lost and many faculty members, he knew, had taken unpaid leave for two years, to wait for the coming regulations (see Appendix A-1).

On the other hand, as a competitive environment is aimed in the health services, most of the public institutions are expected to meet their expenditures on their own. The Legislation of Net Current Assets' effect on the Higher Education Council also supports the fact.¹² According to this legislation, academic members take additional payments, differing from A to D and calculated by different coefficients. The most significant side of the legislation is that while Group A includes income-generating activities, activities of education, research and science are included in Group C and D, which have the lowest coefficients. In that respect, all four of the interviewed professors in university hospitals, agreed on that in medical faculties, income-generating activities were conducted more than education or research activities nowadays and making a medical research had become even more difficult, as the funds, appropriated for those were already insufficient.

Here are some of their opinions about SSI payments to university hospitals:

Professor Doctor 1: "...As to university expenditures, SSI payments are far from being sufficient and the application process has caused a significant bloodletting in university

¹² Döner Sermaye Yönetmeliği,
http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=845:yueksekoeretm-kurumlarinda-doener-sermaye-gelrlerinden-yapilacak-ek-oedemenn-daitilmasinda-uygulanacak-usul-ve-esaslara-lkn-yoenetmelk&catid=2:ymelik&Itemid=33

hospitals. Clinics has become institutions loosing constantly and being far from qualified services. In the present time, SSI pays only 15 TL for an out patient in a psychiatry clinic, however it pays 38 TL (8 TL for the handling fee and 30 TL for the bed service) for an inpatient. Electroconvulsive therapy, called ECT, costs 60 TL, nonetheless SSI pays only 40 TL for it. While this forms a system excluding inpatients, it promotes the outpatient treatment. On the one side, there is a competing system working according to the market conditions, and on the other side there are medical faculties which loose the competition from the very beginnig.”

Professor Doctor 2: “...SSI shares for university hospitals are very insufficient. Now, we are not able to determine the charge of the service, we provide and at the end, we can not afford our service costs and this causes us to make loss as an institution, thus they blame us. However, the main problem is the inadequacy of SSI payments which are far below the costs. This is a hospital and costs are high, in our day, the most profitable patetient for our hospital is the one who is sent by writing a prescription only. If you require rontgens, laboratory tests... etc, the costs get higher. As these are university hospitals, complicated cases apply here and these patients’ costs happen to be high, for sure. ”

As it is seen in the explanations, the payments of SSI are far from the costs of university hospitals which are the major institutions for medical education in Turkey. Again, all the interviewed professors were of the same opinion that SSI payments were not sufficient to meet the expenditures of university hospitals. As university hospitals are not authorized to define their service fees on their own and SSI pays them fees under their costs, these hospitals make loss constantly. There is a tendency to exclude inmate patients, while the outpatient treatment is encouraged.

If we consider the payments that SSI makes to university hospitals, we see that they were higher than the private hospital payments until 2005, yet private

hospital payments increased gradually in the following years. In 2010, payments, made to university hospitals were 3.558 million TL in total, while that amount was 5.420 million TL for private hospitals. (see Table 2.3)

Table 2.3: Total Health Expenditures of Social Security Institution- *million TL*

Years	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total Health Expenditures	7.629	10.662	13.150	13.608	17.667	19.984	25.347	28.811	32.509
Treatment	2.831	4.362	5.906	5.626	8.489	10.267	13.953	15.129	18.469
MoH Hospitals	1.815	2.998	4.083	3.521	5.442	6.399	7.325	7.875	9.584
University Hospitals	620	827	1.079	1.083	1.325	1.523	2.247	2.572	3.558
Private Hospitals	396	538	743	1.021	1.723	2.345	4.381	4.682	5.420
Medicine	4.300	5.615	6.399	7.001	8.372	8.858	10.717	13.161	13.547
Other	498	685	845	980	805	859	677	521	493
Other (Medical Device etc.)	433	573	712	871	659	655	409	225	219
Optic	66	112	133	110	146	203	268	296	274
Ratio of Health									
Expenditures to GDP%	2,18	2,34	2,35	2,10	2,33	2,38	2,67	3,02	2,94

Source: derived from SSI Statistics

In addition, we told that the performance system had caused an industrial type of relation between doctors and patients and that had caused the doctors to prefer

what is yielding and fast. To that extent, one of professor doctors we interviewed stated,

“Performance is an industrial type of reference. It can not be applied in university hospitals. For example, on the basis of piece work, instead of a 50 minute-psychotherapy, one may prefer to examine five patients, spending ten minutes for each of them. This causes moral hazard in health services. Performance system does not correspond to the value of work, it only forces doctors to examine many patients (see Appendix A-1).”

Another professor doctor criticised the performance system for not being a real measurement of examining and stated that:

“Performance system has caused demoralisation of us. I have been working here for 22 years and no one has ever asked each other’s wage for 20 years, but as for the latest 2 years, everybody started to ask each other... Everything started to be consulted by a money-oriented view and the tendency for profitable transactions increased. In performance system, quality or results do not matter. The labour of the doctors is evaluated only in terms of quantity, i.e. the number or the examined patients. For example, let’s say, you examine lots of patients and diagnose all of them wrongly, and even cause the deaths of some and let’s say that there is another doctor who examines lots of patients but does his work right and cures all his patients, the system does not make a distinction between the two examples. All in all, my salary is higher than his. I think, it is wrong to call it performance system. Because performance means considering the result of the service also, but here results do not matter (see Appendix A-2).”

Nearly all of the interviewed doctors who work in public sector stated that the performance system had spoiled the working peace of doctors and caused moral hazard in doctorship. In the performance system, the results of the treatments,

i.e. the success rates are not considered. The system is evaluated to be a quantity-oriented one, in which only the number of the patients, one examines is considered important. On that point, it is thought that the system is based on piecework mentality, rather than the performance of the doctor. Some of the professor doctors explained their opinions about performance system:

“Performance criterias effect health services negatively and spoil the peace of working along with the workplace environment. At this point, personnels should get the base pay advised by TMA, for sure, and only %15 of it should be subject to performance. But today we see quite the opposite; while the base pay forms nearly the %30 of a personnel’s wage, the rest %70 is subject to performance. This caused a moral corruption, although we tried to prevent it (see Appendix A-4).”

“Performance system has caused demoralisation of us. I have been working here for 22 years and no one has ever asked each other’s wage for 20 years, but as for the latest 2 years, everybody started to ask each other... Everybody asks each other how many patients he examined and makes calculations according to numbers, every month (see Appendix A-2).”

Also an executive from TMA, evaluated performance system: *“Performance system kills the spirit of medicine. Doctorship is being defined by fiscal rules. The more operations you make, the more money you get. Let’s say that a patient needs to have 15 tests, but if the doctor wants them all at once, he exceeds the limit, so he wants 5 of them firstly and delays the rest to be had 10 days later. Can something like this happen? The time of diagnosis extends at least 10 days more. In the hospitals which started to apply the performance system, the required medical examinations showed an increase at the beginning, but they decreased again, in time. Why? Because they did not used to keep account of every little operation in the past. Now, the bundle prices are decreased and doctors have to calculate every medical examination they require. Doctors in Turkey still resist to this.”*

In 2009, Ethics Committee of TMA made a survey called The Performance System from the Perspective of Doctors (TTB, 2009). According to the results of the survey %70 of the doctors in Turkey think that the unethical treatments increased, while %52 of them think that the false treatments called malpractice increased after the performance system. Then again, according to the same results, %67.3 of the doctors in Turkey think that the length of time spared for a patient's examination is shortened and %60.3 of them think that the quality of health services showed a decrease. (TTB, 2009, p 36)

Apart from all these, Prof. Dr. Dursun Bugra who left Istanbul Medical Faculty and started to work in the private sector, operated the Prime Minister of Turkey in Marmara University Pendik Education and Research Hospital in 2011. Although everything seems to be right till here, it was prohibited for a doctor who works in a private hospital to make an operation in a university hospital by the full-day law, legislated the same year with the case. This means the breaking of the law, legislated by the government for the same government's prime minister, who is the most authorized one after the president of the republic thus, double standards. One of the interviewed professors pointed out that this was medically unethical and everybody in the country should have the right to choose their own doctors (see Appendix A-3).

Besides these, interviewed academic members of the university hospitals agreed on that they did not consider the increase of the medical faculties in private/foundation universities as beneficial and these were not useful unless provided with enough staff. One of the professor we interviewed gave this remarkable example:

“I am a councillor in the Council of Medical Speciality which is bound to Turkish Medical Association (TMA) and includes members of Higher Education Council. We receive complaints from a foundation hospital’s medical faculty and even from its own residents, working there. When we probe into these complaints, we see that two assistants are on duty all month long, one working for the first half and the other working for the second half of the month; and they complain about not being able to have a qualified education. As a result of the research, seven or eight departments’ of a university were closed. These are the consequences of establishing universities like factories.” (see Appendix A-1)

Additionally, it is known that the government provides a great convenience for establishing private/foundation medical faculties. Exemption from taxes and subventions from government make private/foundation universities a center of attraction for private capital investment groups. That is one of the reasons of the rapid increase in the number of the medical faculties established in private/foundation universities.

According to the researches, in 2010, the number of the medical faculties per one million population was 1.02 in Turkey. Compared to Europe and the U.S.A., this number is higher. If we consider the non-proportional increase in the numbers of students and instructors between 2008 and 2010, it is clear that the situation is not that good. As a matter of fact, in the given years, the number of the instructors increased %8, while the number of the students increased %14 (TTB, 2011/5, p 33). This increase in the number of the medical faculties, as also the interviewers indicated, does not mean that the education and services given in these are qualified. What defines the quality in education and services

is not that rapid increase but it is the teaching staff in the established departments and their qualifications.¹³

¹³ Dr. Eriş Bilaloğlu'nun TTB hakkındaki makalesi http://www.hekimedya.org/oku.php?yazi_id=3544

2.4 The Case of Privately Owned Clinics/ Medical Centers After The Latest Regulations of HTP

Before 1980, the general view in Turkey was that the health services should be provided by the government, so most of the private hospitals then were established by minorities of foreign origins. Yet, in the rebuplic period, the first legal regulation concerning the private health sector was the statement of that “The government can provide health services via private health institutions.” in the constitution of 1982. In the following years, it was stated also in the development plans that the government would give place to the private sector more, as for the further investments in health field. In this respect, although the commercialization of the health services is thought to be caused by the government’s withdrawal from the field, the latest changes in the government’s fixed capital investments prove that wrong. According to the datas of the Ministry of Development and The State Planning Organization (SPO), in the program of 2012, government’s fixed capital investments, made to the health field are planned to be increased %17.4. Also, in the medium term program of 2011-2013, prepared by the State Planning Organization of Turkey, regulatory, planning and supervisory roles are given to MoH, to achieve an increased accessibility, quality and effectiveness of health services, again. (Medium Term Program, SPO, 2010)

Unlike most of the countries, in Turkey, the progress of the transformation in the health field depends not on the dynamics of the market, itself but on enactments of the government. Especially after 2000, the private health sector in Turkey grew via domestic and intertational private capital investments,

partnerships and acquisitions. This growth came also as a result of that the government withdrew its social policies gradually from the field of public services, which was known to be a governmental field then, and left it to the control of the private capital. As to the SSI datas, in Turkey, the total number of the inpatient treatment facilities was 1.439 in 2011, whereas the number of the private hospitals among these reached to 490 then. Most of the private hospital investments are gathered in Istanbul and according to the datas of 2010, the number of the private inpatient treatment facilities in Istanbul is 155 (SSI statistics, 2011).

In general terms, there are four significant trends in the private hospital sector: spreading by hospital chains, the increasing internationalization in the health sector, specialisation, along with consolidation and acquisition. (Karakaş and Yılmaz, 2011, p 94). In the private hospital sector, hospitals are replaced by private hospital chains, whereas the market saturation increases. Medical centers which are out of hospital chains and try to exist in the market on their own are forced to adapt themselves to the constantly changing laws and regulations. With regard to this problem of the medical centers, a doctor who owns medical center stated,

“ They force the medical centers to choose between expanding by integrating or closing, till the end of 2013. %95 of the enterprises today can not meet the required standarts. The regulation as to the selling of these enterprises to big hospitals is prepared. This means monopolisation, in short. We will either be in higher debts to expand or leave this field. I belive that we should stay and fight (see Appendix F-1) ”.

Especially in Anatolia, small-sized enterprises which invested in the field of health at one time but were troubled by financial crises or so then, resort to

merge with bigger investment groups or they are acquired by those investment groups. But the private hospital agreements, made with SSI increased the investments, made to the health field significantly, thus the excess supply of health care services led to trouble many small and middle sized enterprises. This situation shows that the structure of the system, consisting of small and middle sized enterprises will turn in an oligopolistic one, consisting of private hospital chains in the future (Karakaş and Yılmaz, 2011).

In addition, it is known that %75 of health investments are made by private sector. Nowadays, shares of the biggest private investment groups, which own hospital chains took place in the lists of IMKB (Istanbul Stock Exchange). Hence, it shows us that with the transformation in the health field, private investment groups paid more attention to the sector (Yıldırım, 2011).

By the Decree Law of 2008, concerning the private ambulatory treatment facilities, the investments, already exaggerated were hindered via planning. The new decree law almost eliminated the hospitals which have less than 100 beds, including the medical centers, out of hospital chains.¹⁴ Additionally, with the new regulations, medical centers, in a metropole city like Istanbul, were required to have physical conditions, impossible to provide (Resmi Gazete, 2008, Madde 10). As for that, medical center owners stated that they were highly displeased as the regulations were so destructive. A doctor who owns medical center explained the situation, they were in:

¹⁴ ayakta teşhis ve tedavi yapılan özel sağlık kuruluşları hakkında yönetmelik
http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=893:ayakta-tehs-ve-tedav-yapilan-ozel-salik-kurululari-hakkinda-yoenetmelk-2008&catid=2:ymelik&Itemid=33

“ Today, medical centers are forced to be closed and to sell their staff to private hospitals, as they are required to have some regulations which they can not have actually, in the name of enhancing physical conditions. It is said that a medical center has to have a parking area, available for a car in every 125 square metres. They set lots of conditions like “The entrance must be separate.” or “ There must not be any other foundations in the facility.” For a metropolitan city like Istanbul, this is not realistic. For example, the parking issue is under the responsibility of municipalities, in Istanbul. They set the condition of having a parking area, before they give the construction permit for apartments or they build parking areas themselves for a certain price. However, municipalities do not fulfill their duties and thus, you happen to be blamed. Additionally, %70 of the buildings in this city are not constructed properly, according to the rules and conditions set in their construction permits. And the thing is, they created a climate as if the foundation was adaptable for such regulations and we hindered it (see Appendix F-2)”.

It is also known that; the payments of SSI to medical centers are under the expenses of these centers, just like it is the case for the university hospitals. In conjunction with this a doctor, being owner of a medical center gave this example:

“ By the implementation of bundle pricing, when a patient with internal disease goes to a private hospital, Social Security Institution pays a sum between 21 and 24 Liras to the hospital, depending on the hospital’s charging and that includes clinic, laboratory and doctor expenses. And we are let to have only the %30 of this sum as a contribution fee. So a sum like 32 Liras is paid to the hospital and they expect us to meet all the service expenses with that 32 Liras (see Appendix F-2)” .

While the current additional fees, charged by hospitals do not meet even their costs, the medical centers in financial distress are tried to be closed down by such regulations. A doctor who is a medical center owner, stated,

” By the monopolization quality of the HTP, ambulatory medical centers had nearly 15 regulations in the last 4 years. These were all restrictive and compulsive regulations. Later on, the number of these ambulatory medical centers decreased from 1000s to 300s, as I remember. I think, this limited the access to the health services again (see Appendix F-1)” .

So this situation caused differential additional fees among hospitals. We also told that while there are no standards in additional fees charged by hospitals, as for SSI fines, small enterprises are equated to big hospital groups. Such fines put small enterprises in a tight spot, whereas they only slightly effect the high hospital groups. Relevant to the subject, one of the interviewers summerized the situation:

“There is not a standart for the additional fees charged by hospitals, besides private hospitals of big investment groups take additional fees as they will even by paying the fine. At this point, small hospitals are effected mostly, because the progress is towards monopolization; and while big hospitals get bigger, small hospitals are brought to an end (see Appendix A-2).”

One of the interviewed medical center owners pointed out that MoH is the only desicion-making unit and there are not any institutions to control it, and added:

“...the Ministry of Health becomes both the controller and the rival of small and middle sized enterprises, while there is no institution to control it. There are lots of public hospitals which are under the standarts of medical centers and I do not even compare the village clinics. But, they misuse their power to suppress medical centers and so, they lead up to monopolization (see Appendix F-1).”

When the interviewers were asked what they would do, if they were not able to provide the required physical conditions by the end of 2013, all of them stated that they wanted to struggle, that was to say, either they would turn their

enterprises into private hospitals and be in the search of sponsor for these or they would sell their enterprises and work in a private hospital.

2.5 The Health Care Labour Force and Its Current Problems

By the HTP, the change in the quality of the public health services affected both the field of health and the health care staff in Turkey. The fact that in a market-oriented transformation, private public partnership is needed to turn the health services into a supply and demand equilibrium is stated in the recent government policies. In general terms, New Public Management discourse requires a new organisation for the production of public goods and services by privatization, commercialisation, PPP and subcontractation (Ulutaş, 2011).

Changing the existing structure like this could not be succeeded unless a forcing and controlling mechanism was applied on the health labour power. In this respect, all of the medical staff, especially the doctors were confronted with several changes of law. By these changes, several subjects like working conditions, working hours and payments were elasticated.

The compulsory service obligation which was repealed in 2003, brought back in 2005. By the Law No. 657 Clause 4, the doctors working in the public field were allowed to work under contract, apart from their civil service in 2009.¹⁵ This led to the subcontractation of the health labour and all these were highly opposed by healthcare personnel organisations.

As a matter of fact, public health facilities also resorted to subcontractation to minimize their expenditures. The full-day law is thought to be a process to cheapen the health labour in the recently establishing health sector and to cause

¹⁵ 657 sayılı kanun, <http://www.mevzuat.adalet.gov.tr/html/388.html>

depreciation of the health personnels' labour. These were stated in the written declarations of SES and TMA.

Especially by the coming of performance system, the efficiency of the doctors is evaluated in terms of quantities like the number of patients, they examine or the number of prescriptions, they write. And that means expecting the longest and busiest working hours, as possible, from the doctors in the name of performance. This situation, along with the several regulations as to the efficiency of the health labour power show that there is a shift to Taylorism in the field of health. The wage flexibility, brought to the academic members of university hospitals beforehand, was brought also to the public hospitals, additionally, by the the performance system and the full-day law the pressure on the health labour power increased gradually (Sönmez, 2011, p. 92).

As another result of the transformation, it is known that the violation against doctors increased. When asked "It is said that there is an increase on the rates of violence against doctors and health care personnel, what do you think about it?", all the interviewers answered yes. Here are some of the responses we got from interviewers:

A Professor Doctor From A University Hospital in Istanbul: *"...I observe that there is a discrediting policy as to the labour of doctors. To decrease the doctor wages, they try to disgrace the profession of doctorship first. The day before Ankara meeting, the news of a doctor who accepted a bribe in the surgery room was published. When we look at the time of the news, we see that the incident happened 3 months ago, however it was brought up to the agenda again just before the meeting. On the other hand, the way the politicians adress to doctors, their expressions played an important in the process. The prime minister said "I would not let these doctors give me even an*

injection!” and there are other expressions of him, full of anger, all those have a huge impact. All in all, as the patient confronts doctors in the first place, when he goes to a hospital, he reacts to doctors, for sure (see Appendix A-2). “

A Professor Doctor From A University Hospital in Istanbul: *“...the politicians’ speeches against doctors and the catcalls in election meetings are significant, for sure. All these situations cause the doctorship, a respectable profession, to be perceived not as a helpful profession but as a profession that is greedy for money and could cause a harm any time (see Appendix A-3).”*

A Professor Doctor From A University Hospital in Istanbul: *“...the working standards of our assistants are gruelling and unhealthy. Have you ever worked perpetually for 36 hours without any sleep? After 36 hours of sleeplessness, they expect you to give the service and some resort to violence, if they have to wait for a while. Surely, as they confront with mostly the doctors, doctors are the most effected ones from this situation and we loose our friends. They act as if everything goes well in the health system but it absolutely does not. Today, people react to differential fees, charged by hospitals, participation fees and the increasing out-of-pocket expenditures, they get angry with these (see Appendix A-4). “*

As also the views above verify, it is true that there is an increase in the violence against the health care personnel. All the interviewers agreed on that there is an increase in the violence, then again, they were all of the same opinion that the media and the statesmen worsened the situation by their negative expressions and treatments. There was a general belief that the situation was exaggerated by politicians and their incoherent statesmens rather than the patients, the citizens of this country. The statements indicating that the health system is going well cause the patients to react when they are faced to a problem in the practice of the hospitals, in reality. According to the survey of patient satisfaction in the 1st step health services, conducted by MoH in 2011,

the total patient satisfaction rate was defined to be %89.8.¹⁶ After this survey of MoH, in February 2012, Ankara Medical Chamber conducted a survey and in total 290 patients, who had polyclinic examinations in Ankara Numune Hospital, Turkey Postgraduate Hospital, Dışkapı Yıldırım Beyazıt and Ankara Keçiören Training and Research Hospitals were interviewed face to face. With regard to the results of the survey, considering that there is an increase in the violence against the health care personnel, it is clear that we have a contradiction. About this, an executive of TMA said,

“It is obvious that the violence against doctors increased. The manners and expressions of the politicians are very bad. The Prime Minister said “I would not have even an injection, it might paralyse me, for gods sake!”, if the prime minister of a country says that, you can not expect the society to respect the doctors. The commercialisation of the service is influential here, as the patients feel like customers now and act as if they bought something by paying money. In the past, the respect the society felt for the doctors was high and this created a barrier between the doctor and the patient. But now, when a patient meets a doctor, he thinks that he can beat him... we see the minister of this government on TVs in the evening, saying “Everything is very good in health field, there is no problem.” The next day, when something goes wrong in the hospital, the patient thinks that the minister told that everything was perfect in the health field, if there is a problem, it should be caused by the doctors. They say that the patient satisfaction increased, though we see the increase of violence against doctors, also. So what is happening? Do the patients beat doctors when they are satisfied? The expectations of the patients are exaggerated by statements like “Every thing is perfect in the health field.” Rather than the patients, politicians are to be blamed here (see Appendix B-1).”

¹⁶http://ekutuphane.tusak.gov.tr/kitaplar/birinci_basamak_saglik_hizmetlerinde_hasta_memnuniyeti_2011.pdf

Also, considering the increase in the violation against doctors, TMA prepared a workshop about that in 2009.¹⁷ According to the Report of Violence in Health Sector, carried out by Gaziantep Medical Chamber, %90 of the doctors who participated in the survey think that the violence in the health sector increased, additionally, %10 of them think that the state, the governmental and juridical problems lay beneath the violence acts in the society. Whereas %18 of the doctors state that the health policies of the government is the cause. On the other hand, one third of the doctors think that the media makes them a target by publications to the detriment of doctors and harms the doctor-patient relationship and their working peace.¹⁸

Also this research shows that there is an increase as to the violence against the doctors and the health care personnel. In addition to this, the regulation considering the security of the health care personnel was promulgated on the official journal for the first time on 6 April 2011.¹⁹ Although MoH seemed to take an action about the issue for the first time, when the regulation was studied, it was understood that the responsibility was laid mostly to the head doctors and/or executives of the hospitals.

¹⁷ <http://www.ttb.org.tr/siddet/images/file/itocalistay.pdf>

¹⁸ <http://www.ttb.org.tr/siddet/images/file/gaziantepsiddet.pdf>

¹⁹ <http://www.resmigazete.gov.tr/eskiler/2011/04/20110406-3.htm> HASTA VE ÇALIŞAN GÜVENLİĞİNİN SAĞLANMASINA DAİR YÖNETMELİK

3. Conclusion

The paradigm shift in the perception of social state nowadays has affected Turkey as well as South European countries and continues to do so. Turkey possesses all the characteristics that Ferrera has observed in these countries. The clientelist mentality present in the provisioning of public services, political parties which have relationships based on self interests, the existence of an informal sector that has been enlarging through the years act as obstacles to employment of both economical and social policies. Besides, the financial crises taking place on a globalized scale where all the markets systems are interlinked result in welfare state retrenchment. This issue entails social policy, education and health system reforms in countries with a collapsing economy that are subject to such crises.

What caused the neoliberal policies in the health field that started before the JDP government, in fact, to be considered as different, was that it was turned into a progressing system which was made functional with the consent of the public produced by populist statements and manners of JDP.

Today, as the state leaves the field of its public service responsibilities slowly, the newly open space is rapidly marketised. Considering that politicians are affecting the whole public by their speeches via media, commercialization, marketization and so privatization on health is completed with zero problem by government.

In a system where the bigger investment groups' chain hospitals grow gradually by increasing shares, while small-sized enterprises, out of these chain hospitals

are forced to expand or to close down by the constantly changing regulations, the oligopolistic structure likely to occur will be the end of the understanding of health as a human right, granted everybody in equal terms.

Today, medicine faculties as higher education institutions, are struggling with the profit-oriented policies which cause a reduction in their quality of educate, research and raising phsycians. The effects of these kind of policies only can be seen in the long run, thus the near future of health education and doctorship in Turkey, does not seem good.

With the commentaries of interviewers that was conducted in this research, it is comprehended that the commodification of health care services did not improve the quality of services given in the hospitals during the recent health policies.

While the health labour process is completely commodified, there is a huge increase in the quantity of the health services, examinations in hospitals whereas the quality of them is getting lower. All the interviewers replied "Bad" as to the change in the service quality of university hospitals and privately owned medical centers, whereas most of them affirmed that the access to health services got easy, then again, they explained that this did not mean an increase in the service quality. It was revealed that the notions of service quality and service accessibility were confused in the eye of the public.

On the other hand, the results of the interviews showed that the health care personnels think that the applied health policies affect the system and them, as a part of the system, highly and in negative terms.

Lastly, it is not possible to generate an egalitarian health system by leaving the field for private sector without responding the needs of society. HTP, served as a unique reform, is not responding public health needs with market oriented implementations. It is obvious that, such an understanding of reformation, being consumption-oriented rather than being patient-oriented and not considering the working conditions and hours of its personnel, will not bring the system to a higher level in the near future. Considering all, these kind of populist reform programs have to be canceled and a system have to be used that is fair and equitable to both health labour force and citizens.

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Appendix A

Interviewer 1; A Professor Doctor From A University Hospital in Istanbul

University hospitals can not be expected to profit. Firstly education, secondly research and finally comes the presentation of the service. Troublesome, advanced and complicated cases which require special knowledge and skill are looked after in university hospitals. The old system also had its own positive and negative sides, open to question but the change could not be a truly good one.

With the full-day law, the government withdrew from these hospitals' financing. A new approach valuing quantity more than quality occurred, which means that the more patients you examine, the more money you get.

Performance is an industrial type of reference. It can not be applied in university hospitals. For example, on the basis of piece work, instead of a 50 minute-psychotherapy, one may prefer to examine five patients, spending ten minutes for each of them. This causes moral hazard in health services. Performance system does not correspond to the value of work, it only forces doctors to examine many patients.

By the Decree-Law No.650, medical faculty members were prohibited from examining patients in university hospitals, if they own or work in a private clinic; they can only give education now. This caused %40 of the faculty members to be lost. Many faculty members, I know, took unpaid leave for two years, waiting for the coming regulations.

As to university expenditures, SSI payments are far from being sufficient and the application process has caused a significant bloodletting in university hospitals. Clinics have become institutions losing constantly and being far from qualified services. In the present time, SSI pays only 15 TL for an out patient in a psychiatry clinic, however it pays 38 TL (8 TL for the handling fee and 30 TL for the bed service) for an inpatient. Electroconvulsive therapy, called ECT, costs 60 TL, nonetheless SSI pays only 40 TL for it. While this forms a system excluding inpatients, it promotes the outpatient treatment. On the one side, there is a competing system working according to the market conditions, and on the other side there are medical faculties which lose the competition from the very beginning.

By the Decree-Law No.663, medical faculties which are thought to be mismanaged or not to be managed effectively are planned to be bounded to the Ministry of Health. It is not certain yet, but it is sent to the constitutional court and the results are expected soon.

If it passes, head doctors and the administrative staff will be determined by the Ministry of Health, while the dean will be responsible for education only.

On the other hand, The Decree-Law No.663 may provide faculty members with flexible working models and the chance to work under contract and this also adds another dimension to the case. Faculty members working under contract are members who are dependent to the annual contracts and go to schools only for lecturing, which means members whose personal rights are revoked.

As for the project of integrated health campuses, the aim is to constitute campuses working effectively, but here the university hospitals are excluded, this change aims to put a distinction between hospitals and medical faculties. A qualified education and research can be provided only by the combination of medical faculties and hospitals, but this is tried to be cleared off. And choosing between changing and perishing is the only choice, left for us. Because of the fact that the number of the patients you examine became more important than your education, as for Medical Faculty of Istanbul, education and schools are in the process of vanishing.

Patients are generally satisfied with the Health Transformation Program (HTP). The access to the health services got easier. The coverage is extended, yet we are experiencing a decrease in the quality of the service. There is a bloodletting in universities, as they are constantly losing their qualified personnels and educational qualities, nowadays. After a while, they will become institutions in which lots of patients are examined, yet a regression in terms of education is witnessed.

The increase in the numbers of operations and transactions is a result of the consumption-oriented approach to the health system, which values only the quantity. Nowadays, while there is an increase in the numbers of Group E operations like appendicectomy or cholecystotomy performed in university hospitals, Group A operations, which are advanced cases, are performed in private hospitals. Whereas, university hospitals were where Group A operations were performed and thus the residents were educated in the past. The period is thought to be a short one, though in the long term, education will go wrong in the next ten years.

The increase in the number of the universities in Turkey is more than 1 in a million. However, we do not have academicians and the staff is not ready, so we have the case of insufficiency in quality despite the increase in quantity, again. Foundation

hospitals are established for the sake of profit, as in our day, medical faculties are known to have more qualified personnels, thus to be more prestigious and have a better service quality. And the private capital invests a good deal to this field, for sure. I would like to give an example as to that, I am a councillor in the Council of Medical Speciality which is bound to Turkish Medical Association (TMA) and includes members of Higher Education Council. We receive complaints from a foundation hospital's medical faculty and even from its own residents, working there. When we probe into these complaints, we see that two assistants are on duty all month long, one working for the first half and the other working for the second half of the month; and they complain about not being able to have a qualified education. As a result of the research, seven or eight departments' of a university were closed. These are the consequences of establishing universities like factories.

HTP caused a conflict between the doctors and the patients. Published by the media, some sayings of politicians like "Doctors are greedy for money" or "I will make these professor doctors examine some patients" are also influential for that matter. SABIM (Contact Centre of Ministry of Health) is established. Doctors have to adapt themselves to these situations.

Interviewer 2: A Professor Doctor From A University Hospital in Istanbul

First of all, the general philosophy of the HTP is wrong. As they have already commodified everything they could, in the world, it is time for the commercialization of health. This change is not experienced only in Turkey, but Turkey is a pilot region, still developing as to that. If you evaluate the program in terms of sections, you may come up with a good picture, but in general the progress of the program is bad. Today, everything goes bad in university hospitals. As they aimed to have campuses bringing hospitals together, they had to include university hospitals also. Being applied in the public hospitals first, the program was applied to university hospitals later, but we showed the greatest resistance. As we did not submit directly, they try to wear us down by causing financial distress for us and expect us to submit that way.

University hospitals in Turkey can not get any help or contribution from the government, so they are all in debt and serious financial difficulty. Why do they do that? University hospitals are not many in number, in fact, however these are hospitals,

having high brand equity. In our day, a case that can not be cured in any other hospital applies to university hospitals. And this makes them the leader in the field. This system wants the brand to be only in the private sector.

On the other hand, doctors' wages were decreased. If you get into a field which serves to the market economy, the wages should be decreased to a level, for sure and this is what is happening to us, doctors now. The educational aspect of the matter is ignored completely. In long term, after 10 or 15 years, Turkey will not be able to raise qualified doctors. Now, the government is interested in how many patients are examined, only.

Private hospitals... Why are these established? On the purpose of profit or raising employees for their own companies and gaining prestige, as it is the case in Sabancı and Koc Universities. If you look at the private university hospitals, you will clearly see that they are established for the sake of profit. Because when you establish a medical faculty in a private university, you are exempt from lots of taxes and this means that you have a more profitable entity than those other private hospitals as your expenditure is lower. Most of the newly established ones in Turkey suffer from the lack of substructure, they can not establish their own departments as it costs a lot and it will not be profitable.

The access to the health services got easier, right, but why? If you are going to product something, you increase the demand firstly; in a colloquial manner, you get your customers' feet under the table, before you increase the prices. For example, at the beginning of the program, the association of Pension Fund, Social Insurance Institution and the social security organization for artisans and the self-employed, called Bağ-kur was viewed to be something good, as people were able to go to private hospitals with their SSI insurance from then on. They did not spend hours at long rows any more. These were thought to be good things at the first sight. But nobody questioned why the incomes they received were not used for the old public hospitals' enhancement instead of being invested in the private sector. As the next step, they started to require contribution margins, medicine fees... etc. and they charged the patients with additional fees.

There is not a standard for the additional fees charged by hospitals, besides private hospitals of big investment groups take additional fees as they will even by paying the fine. At this point, small hospitals are effected mostly, because the progress is towards

monopolization; and while big hospitals get bigger, small hospitals are brought to an end.

By the public hospital associations law, Ministry of Health became the biggest holding company of Turkey and similarly, public hospitals became the biggest enterprises of the country. And do you know what is really interesting about it? To be an administrator in public hospital associations, it is enough to be a college-graduate and to have 5 years of experiment in an enterprise. I mean, somebody who worked for an exchange office in Tahtakale for 5 years can be an administrator in these associations. He is not expected to have any health education for that.

On the other hand, with the latest regulations, academicians doctors are told not to examine patients but to give education only. The government is not able to see how impossible this is. As to medical education, one can not be a doctor without seeing any patients, it is not possible.

SSI shares for university hospitals are very insufficient. Now, we are not able to determine the charge of the service, we provide and at the end, we can not afford our service costs and this causes us to make loss as an institution, thus they blame us. However, the main problem is the inadequacy of SSI payments which are far below the costs. This is a hospital and costs are high, in our day, the most profitable patient for our hospital is the one who is sent by writing a prescription only. If you require rontgens, laboratory tests... etc, the costs get higher. As these are university hospitals, complicated cases apply here and these patients' costs happen to be high, for sure.

Performance system has caused demoralisation of us. I have been working here for 22 years and no one has ever asked each other's wage for 20 years, but as for the latest 2 years, everybody started to ask each other... Everybody asks each other how many patients he examined and makes calculations according to numbers, every month. There used to be a standart working capital fund, and associate professors, professor doctors, they all used to get the the same share from it. Now, there is a differential payment distribution which changes among clinics and even among the employees of a clinic. Everything started to be consulted by a money-oriented view and the tendency for profitable transactions increased. In performance system, quality or results do not matter. The labour of the doctors is evaluated only in terms of quantity, i.e. the number or the examined patients. For example, let's say, you examine lots of patients and

diagnose all of them wrongly, and even cause the deaths of some and let's say that there is another doctor who examines lots of patients but does his work right and cures all his patients, the system does not make a distinction between the two examples. All in all, my salary is higher than his. I think, it is wrong to call it performance system. Because performance means considering the result of the service also, but here results do not matter.

I do not know how the university hospitals' future will be, however it is obvious that they are not going well and will not end up being well. According to a research, 1/3 of the doctors in U.S.A. plan to stop practicing their professions in the next 10 years. If the research was done in Turkey, the rate would be higher. As a matter of fact, I and my friends think about when we will be retired and will get rid of all. I have a 17-year-old daughter, who will go to university and I definitely do not want her to be a doctor

As for the violence against doctors, I observe that there is a discrediting policy as to the labour of doctors. To decrease the doctor wages, they try to disgrace the profession of doctorship first. The day before Ankara meeting, the news of a doctor who accepted a bribe in the surgery room was published. When we look at the time of the news, we see that the incident happened 3 months ago, however it was brought up to the agenda again just before the meeting. On the other hand, the way the politicians address to doctors, their expressions played an important role in the process. The prime minister said "I would not let these doctors give me even an injection!" and there are other expressions of him, full of anger, all those have a huge impact. All in all, as the patient confronts doctors in the first place, when he goes to a hospital, he reacts to doctors, for sure.

Interviewer 3: A Professor Doctor From A University Hospital in Istanbul

The art of medicine has become a commerce field in the name of this health transformation programme. As the number of the patients, the doctors examine, became the most important criteria, quantity turned out to be more important than quality; and so the quality of patient care services decreased.

They caused a conflict between the serving, i.e. the doctors and the served, i.e. the patients. The relation which has been lasted for years in mutual love and respect is perceived to be an ordinary service now, and doctors are blamed for every negative

happening in the health sector. Every day, in accordance with the increasing violence acts in the society, we witness verbal and physical violation acts against doctors.

The laws and decrees which were announced and denounced every day, continually worried the ones who spent long years in this profession and laboured in the education field for years, particularly the academic members. Lots of academic members retired earlier or took unpaid leave, as they could not foresee what regulations might come tomorrow.

University or education and research hospitals' first aim, as it is stated in their names already, should be providing education and raising good doctors for our future. However with the latest regulations, neither the academic members who have worries about their future at that age, nor the students with work overload who lack even the slightest positive expectation for their future and should have education actually, have the time and motivation for education.

"The access to health services got easy.", this is the most common expression, that we hear. Is it really so? I do not think so. Every day, people search for an available bed for one or two hours alone in our clinic. If the citizen, who is served, does not have a serious health problem, right, the access to health services got easy. By some extra pays that are low now but probably will increase rapidly soon, they can get examined even by several doctors in a day. And this causes nothing but an unnecessary increase both in the workforce and probably in the medicine expenses. But, if you have a vital health problem and need the expertise of some doctors that are only a few in Turkey, things get really problematic. I work in one of the biggest university hospitals of Istanbul and still, we are not able to admit all our patients to the hospital.

I think, the performance system is bad. Even the patients report us to the Ministry of Health if a patient stays longer than ten or fifteen minutes in the examination room. We feel sorry about these situations, for sure. By the way, we get really fast returns from Ministry of Health...

When it comes to violence against doctors, it is a reflection of the violence that is increasing in the society, unfortunately. If we can not prevent the violence in the society, in a profession which is directly related to society, it is hard to avoid violence acts.

But the politicians' speeches against doctors and the catcalls in election meetings are significant, for sure. All these situations cause the doctorship, a respectable profession, to be perceived not as a helpful profession but as a profession that is greedy for money and could cause a harm any time.

Though the bad examples of the profession should be ended with proper precautions, they are intentionally thrust to the forefront and attributed to the whole profession in general. Doctors are also members of this society, just like lawyers, housewives, greengrocers or politicians... As it happens in all occupational groups, besides the honorable majority, who are devoted to this divine profession and defend what they believe, there are also some doctors who choose to be in the wrong for the sake of personal benefits and does not even feel bad about it.

When it comes to the financial situation of universities, first of all, I should state that education is important... A medical faculty member or student should not be worried, questioning "Which law will be introduced tomorrow?" or "What if I exceed the limit by requiring this test from the patient?". The quality of health services in the future will be determined by the doctors we raise now. The changes that are made today do not show their effects as early as tomorrow, but unfortunately, we see them only after five or ten years, and once a problem is detected, it takes five or ten years more to fix it...

As for medical education, unfortunately, the future is not hopeful for students. Generally, smart ones do not even want to study medicine any more. Sadly, when my son will try to choose a profession, doctorship will be the only choice that I will hinder him from.

As university hospitals are always in financial difficulty and have the problems mentioned in your previous questions, they are losing their educational qualification gradually. There should be a quite big difference between university hospitals and service hospitals. Students can not have a proper education without patients, for sure, but we have a case of overdose as to that. Just as law students or lecturers of any university are not obliged to do all the work of Umraniye Court House too, similar regulations should be made also for university hospitals. In a university hospital, it does not matter how many patients with upper respiratory infection are examined or how many appendicectomies, which could be done in any hospital, are performed, it is the quality what matters... University hospitals are where we perform operations which can

not be performed anywhere or handle undecipherable cases. Sometimes, we, three professors, may spend a whole day for a patient or we may need to discuss for three hours about a patient's case. What is the quantitative equivalent of such a performance: zero, zero and zero again.

If you consider the number of medical faculties per population, we, as Turkey, are the first country. You may think that we are the first at something, at least. We have medical faculties in all our provinces or near by places around them now. Establishing a university or a faculty without having a proper background is already inconvenient, under all circumstances. But as to medical faculties, the inconvenience is even bigger. Education in these new founded faculties is really insufficient and we do not have independent and authorized companies to control them as U.S.A. has. Medical faculties are established expeditiously and inattentively. Their purpose is to raise a large group of unqualified doctors, then turning them into the thousands who wait to be inducted just like teachers and finally, ill paid doctors who work under contract... These are their aims... Besides, an unconfident occupational group with questionable professional skills would not cause trouble and that would be good...

Unfortunately, Marmara University could not have a university hospital since its foundation and was in the group that was effected the most and the first by the financial difficulties. As it is assigned to the Ministry of Health, there has been some developments. Now, we have a hospital. However, we still have the problems that you mentioned in your questions: an intense load of patients, quitting academic members and the lack of time and motivation for education.

On the other hand, I think, the project of integrated health campuses is one of the most significant steps on the way to the commercialization of health that has been tried for some time. Even, looking at the intended managers of the campuses gives us the clues about what awaits us in the future... Finally, I would like to add that if you know anybody who wants to be a doctor, tell him not to be. (Smiles.)

Interviewer 4: A Professor Doctor From A University Hospital in Istanbul

We as doctors were working with amateur spirit in the past and we still try to keep that spirit. We believe that when it comes to education, profit can not be an object. The education of our students and assistants is far more important than this profit-oriented

managing style. By Decree Laws No. 651-653-600 and the neoliberal policies, the amateur texture, here, started to be evaluated according to its profitability in management mostly. There occurred serious problems about patient care services. HTP caused a negative change as to hospitals' service quality. But we are doctors and we try to minimize these as much as we can, with the help of our students. For example, i am using my annual leave now but i am here at the hospital, because there are patients who need help. Doctorship has always been on the stage of history and will always be; it can not be defined or evaluated by economic criterions. I have just come from downstairs. There is a child, crying in pain. According to that sense of management, we should require this and that firstly to start his treatment. There is a procedure, however we do not act exactly according to it, as we did not lost our ameteur spirit. Doctorship is to wish for the well being of people, it is a state of goodness and can never be thought in terms of profit; it can not be performed this way.

Nothing on earth can be thought to be purely good or bad. HTP has also a good side for sure: The access to the doctors has got easier and there is an increase as to the recording of the transactions. Yet, there is something important: You have to consider the opinions of the actors in the system, if you want to change something. Health care personnels should be the most important desicion makers here. Most of these aforesaid health policies are applied despite the personnel's will. Therefore we confront with serious difficulties. Doctors are the performers of this profession and the changes are made without taking their opinions.

Access to health services has got a little easier, right but we should make a distinction here, these are third step health facilities, i.e. the hospitals where the ones with serious health problems and complicated cases apply. However, much more ordinary cases apply to these, as there is not such a distinction anymore and that hinders the patients with serious health problems from taking health services. In fact our development here as an educational facility is prevented, that is to say university hospitals are in difficulty seriously. I think this is what really matters, the most important issue.

Turkey has five big medical faculties: İstanbul, Cerrahpaşa, Hacettepe, Ege and Ankara and all of them are said to be making loss now. But the main aim of medical faculties is education and as to that, it is not wise to have executive changes on account of the fact

that they make loss. This is a profit-oriented view and it endangers the educational qualifications of these faculties.

Performance criterias effect health services negatively and spoil the peace of working along with the workplace environment. At this point, personnels should get the base pay advised by TMA, for sure, and only %15 of it should be subject to performance. But today we see quite the opposite; while the base pay forms nearly the %30 of a personnel's wage, the rest %70 is subject to performance. This caused a moral corruption, although we tried to prevent it. As the poet says, "All the colours were soiling at the same speed. White was given the first prize.", the white apron is having the same situation now, but i believe that the doctors of this country will not let this dirtiness to happen.

They want to demolish university hospitals, their qualifications are being lost. The privatization of these is also talked about. University hospitals are for raising students and doctors. The latest changes do not allow us to spare as much as 40 minutes to a patient who used to be examined in such a period of time. The piece work system, called Taylorist production means the end of the university hospitals. Doctorship is not the work of producing machines on a production line. This situation effects the texture of doctorship and the health rights of people badly and this will end up to the detriment of the society after a while. The society seems to be satisfied for now, because there is a great eye wash. Nonetheless, the loss of qualifications will be visible in time and this will cause great difficulties in the future. The spirit of doctorship is being lost and absorbed by the Fordist mass production model. I am pessimistic about the future of university hospitals and lots of people are aware of the situation too.

On the other hand, as the access to health services got easier, the violence against doctors increased, in fact. One of our assistants has a metaphor for the situtation and i strongly agree with him, he says "They expect us to work like Mc Donalds workers. You know, you go to the restaurant and they ask you quickly 'What would you like to have?' and your order is filled immediately." It seems like they want us to do the same. And all these causes violence. For examble, as one of our newcomer assistants sits here, a man comes with his sick child at about 12:15 and yells at him with anger: "The government pays you and you just sit here!"

On the other side, the working standards of our assistants are gruelling and unhealthy. Have you ever worked perpetually for 36 hours without any sleep? After 36 hours of sleeplessness, they expect you to give the service and some resort to violence, if they have to wait for a while. Surely, as they confront with mostly the doctors, doctors are the most effected ones from this situation and we loose our friends. They act as if everything goes well in the health system but it absolutely does not . Today, people react to differential fees, charged by hospitals, participation fees and the increasing out-of-pocket expenditures, they get angry with these.

The administration of a university is autonomous and it should stay so. Establishing medical faculties should not be so easy for private universities. But let me give you an example, I have an acquaintance who used to run an astro turf bussiness and said that he would establish a private vacational high school for health, complaining that his bussiness was not going well, and who did it actually. We have such situations in this country.

As for the integrated health campusses, i think, these are the first step towards the privatization of the whole health system and the next step will be the commercialization and selling of these...

Appendix B

Interviewer 1: An Executive From Turkish Medical Association

Health reforms started like a worldwide epidemic, in fact. Although the government never accepts it, there is a privatization process, clearly. With the European Union Program of 31 December 2008, health field was taken into the scope of privatization for the first time. The performance system and the GHI as the details of the program were already defined by the agreements of WB and IMF, particularly by the 19th Stand-by Agreement. During one of my panel discussions, I mentioned that I followed the political changes in the health field by IMF's web site and hereupon, i argued with an AKP parliamentarian.

The access to health services got easier. While the number of applications, made to medical facilities was 3 or 4 per individual before the program, it increased to 7. With this point of view, yes, the access got easier, however we can not make the statement by considering only these numbers. As a matter of fact, your application to a medical facility does not mean that you get a qualified health service. But, are there any improvements in the service quality? Nobody answers that, even the Ministry of Health stays quite about the question. Then again, it is said that the examination lenghts were shortened and thus, they became insufficient. As for the examination lenghts, there is no standart, because they all vary according to the patients, branches etc... If you do not spare enough time for a patient and if this patient can not recover even though he applies to the hospital for 8 or 10 times, the number of the accesses to the hospital does not matter. Thus, the ministry always talks about the quantity and never mentions the quality. So, what is the use of this system? It becomes a highly consumed, commoditised good, just as the market needs it to be. The system becomes subject to consumption rather than providing patients a better service. In the past, people were not able to get in hospitals because of the congestion, now they can easily get in but is there a change about the service quality in these hospitals? I do not think so.

Surely, every investment to the health field can make a change for the betterment of the system. For example, SII hospitals used to be very crowded in the past; in that manner, it is good that the hospitals are united to be SSI, now. However, this could be done without removing the property of SII hospitals. But, to create a market, they had to seperate financing from serving. Those SII hospitals are becoming consortiums by

public and private sectors' partnership. There has been a great improvement since the beginning.

We as Istanbul Medical Chamber find out that there are 11 new modes of payment. While it was said that we would not make any payments to hospitals, as all would be paid by our insurances, 2 years later, in 2008, they started to take additional fees, charged by hospitals. These fees, charged by private facilities started as %30, however they increased to %90 gradually, that is to say, the psychological limit was exceeded in the public eye. Now, people know that they can go to private hospitals by their SSI, however they will have to pay a sum and this sum will be defined by the market. Thus, if you pay the fees which differ in every private hospital, you can have their services.

A practice called exceptional health service has been brought. It is possible to do an operation by using either classic or robotic surgical methods now, however the amount you agree to pay defines the method for you. For example, an 80-year-old patient comes and wants to have cholecystotomy by robotic surgery. It is right that he will have less pain, will recover sooner and be discharged sooner, but the cost for such a surgery is 8 billion Liras. The classic surgical method has been held for years, but it is cheaper. In this case, I should ask the patient if he has the money in the first place, then use the robotic method if so and the classic method if not. HTP causes inhuman and unethical situations.

If you already have a GHI, why would you need a collateral assurance? The only explanation is that the GHI coverage is insufficient, it does not cover all and thus there is a need for collateral insurance. After 20 or 30 years, we will have such a public system that we will apply only if we have a crucial situation and GHI will pay for their minimum expenses. I think, this is enough to call it a bad program.

Probably, there has not been any program which spoiled the practice of family care doctors to such a degree. I remember the advertisements of JDP during the first elections, there is a headscarfed woman who holds a prescription in her hand and she says "I go to whichever hospital I choose, I get examined without waiting in the queue, I get my medicine from whichever pharmacy I choose, in addition, I have a family doctor!" Normally, family doctors are entrusted to be the gate keepers of the health system in the first step facilities. The woman already says "I go to whichever hospital I choose.", which also means "I do not have to go to my family doctor." additionally. If

there were a good referral chain system, the first medical personnel that the patient saw would be the family doctor, however there has been 8 years since we do not have the system in this country. As the village clinics are geographically the closest medical facilities in rural areas, people naturally obey the referral chain there, however as for the cities, those clinics became where people go to be prescribed only, as they can already go to every hospital they choose. At this point, who can talk about the performance of family doctors who only does the work of prescribing?

Performance system kills the spirit of medicine. Doctorship is being defined by fiscal rules. The more operations you make, the more money you get. Let's say that a patient needs to have 15 tests, but if the doctor wants them all at once, he exceeds the limit, so he wants 5 of them firstly and delays the rest to be had 10 days later. Can something like this happen? The time of diagnosis extends at least 10 days more. In the hospitals which started to apply the performance system, the required medical examinations showed an increase at the beginning, but they decreased again, in time. Why? Because they did not used to keep account of every little operation in the past. Now, the bundle prices are decreased and doctors have to calculate every medical examination they require. Doctors in Turkey still resist to this.

It is obvious that the violence against doctors increased. The manners and expressions of the politicians are very bad. The Prime Minister said "I would not have even an injection, it might paralyse me, for gods sake!", if the prime minister of a country says that, you can not expect the society to respect the doctors. The commercialisation of the service is influential here, as the patients feel like customers now and act as if they bought something by paying money. In the past, the respect the society felt for the doctors was high and this created a barrier between the doctor and the patient. But now, when a patient meets a doctor, he thinks that he can beat him. On the other hand, we see the minister of this government on TVs in the evening, saying "Everything is very good in health field, there is no problem." The next day, when something goes wrong in the hospital, the patient thinks that the minister told that everything was perfect in the health field, if there is a problem, it should be caused by the doctors. They say that the patient satisfaction increased, though we see the increase of violence against doctors, also. So what is happening? Do the patients beat doctors when they are satisfied? The

expectations of the patients are exaggerated by statements like “Every thing is perfect in the health field.” Rather than the patients, politicians are to be blamed here.

Integrated health campuses are needed to carry on this program, i.e. to maintain the process of commercialisation. And university hospitals happen to be one of the biggest obstacles on the way of HTP. In our day, Marmara University is bound to Ministry of Health, it was said to be bound to the Ministry of Health in terms of administration only and be academically free. How can an academician doctor who is charged with 8 hours of work by the Ministry of Health make academic researches or give lectures? Your academic life is ended, in this case. Or if the government does not provide the needed allowances for the researches of these academicians, what is the use of academic freedom? As for the integrated health campuses, their buildings and managements are said to be publicly owned however all of their staff or executives are not public employees and even, they do not need to be related to the health sector to work there. The managers will consider accounting records only and pay attention to profitable departments. Ankara Etlik Hospital went out to auction by 2.3 quadrillion Liras as the so called integrated health campuses would be established. However, these hospitals will be built by the private sector and their management will belong to the private sector for 25 years and Ministry of Health will provide only doctors and nurses for these. In fact, they are said to be formed by the public and private sectors’ partnership, however these will be facilities taking most of their services like automation, parking and laundry from the private sector. Thus, I can not even foresee the prices that await for the patients applying to these. I would not like to say this, but, when even the public hospitals are turned into these campuses, it seems like people will long for the current system in the future.

Interviewer 2: An Executive From Turkish Medical Association

Before HTP, university hospitals were bound to the Council of Higher Education, although they had autonomous administrations. There used to be a referral chain system, for example, a patient with the SSI could not go to these hospitals directly. And the primary aims of these institutions were education, i.e. raising students, and providing health services. These institutions continued providing education and health services by taking the pay defined by themselves from SSI in return.

After HTP, Pension Fund, Social Insurance Institution and the Social Security Organization for Artisans and the Self-Employed, called Bagkur were combined and turned into Social Security Institution (SSI). The referral chain system was repealed and the access to the university hospitals was enabled. This caused two problems. Firstly, the work load of these hospitals increased and secondly, the medical faculty expenditures were constrained on the basis of bundle prices with the introduction of the pays defined by Notice of Health Practices, called SUT; and that rendered them unable to afford even their own services' cost and turned them into loss makers, as it spoiled their financial structure. Today, as Marmara University was handed over to the Ministry of Health, it became an institution whose financial and administrative autonomy was taken away and which was given only the right of educational autonomy.

Liberalisation in health as an expediated model, melts all the hospitals as well as university hospitals in a pot and moves towards the next step, i.e. the health campuses. And it continues to make investments in the private sector by requiring all the technological and architectural services; and human resources, needed, from the private sector. This system belongs to World Bank in terms of project, though it belongs to international investment groups in terms of investment.

General Health Insurance is an insurance from which every employee can benefit by paying extra premiums. While the premiums paid before were enough both for health services and pension pays, now they started to require extra premiums suggesting that the premiums are not enough. Participation fees, unstandardized additional fees and medicine expenses has also increased out-of-pocket expenditures significantly. Being explained in Gramsci's model, while the changes were made, the social consent was provided.

In fact, university hospitals made loss because they worked for SSI. The government used the loss as an excuse and put the performance and fund systems into practice. As a result of the system, consumption in health and the argumentative cases of surgical indications increased. Doctors started to avoid risky cases and tended towards less risky treatments, which means occupational degeneration.

As to the medical centres which did not got involved in the chaining system, we should begin with the period of Özal, after 1980. The fast growing cities created fast growing skirts and ghettos like Okmeydanı, Sultanbeyli, İkitelli and Bağcılar, at the time of Özal.

As the growth of the public services could not keep up with the fast growth of cities, there emerged private polyclinics firstly and then the private hospitals. The circumstances of the time were such that even two patients could have to share a bed. This was the one aspect of the things. Another aspect to all these was the emergency of a new bourgeoisie class, demanding a more elite and privileged health service. The mentality of hotel management started to get into health services at this point.

By the year of 2000, the process progressed on its own dynamics. It became more common mostly at the west, i.e. centering İstanbul in the first place and then spreaded to Ankara and İzmir. As I observed, with the government of JDP, there started a liberalisation in all fields of public services. Also in the health sector, the tendency to monopolisation caused by the growth paved the way for the international investment groups. Today, the country polyclinics and hospitals bound to small investment groups or individuals exist thanks to SSI payments. As the building expenses and other expenses are low in Anatolia, those entities can exist with the low paid contribution margins. But that is not the case in Istanbul and therefore, contribution margins are higher. Now, the government defined the contributions of these private hospitals to be between %30 and %80. However, these contributions are never taken according to the law, hospitals always require higher payments. When it comes to audits, small hospitals get the same cash fine with the big hospitals. For example, a 50 billion-fine may be only one patient's payment for a big hospital, while it equals to 10 or 20 patients for a small hospital. Small hospitals are aggrieved. In a manner of speaking, rather than auditing these additional fees, SSI acts with a saying of "Do whatever you want but do not let me see or you will be punished!" Because the management of a private hospital is not possible with the pays defined by SSI.

Nowadays, the small hospitals which did not participate in the chaining system fell behind the rivalry and started to break down. Because incentive premiums provided for the big hospitals in the chaining system spoiled the competitive environment. While especially the investment groups close to the JDP ideology experienced a great advancement, others were excluded. The hospital chain of big investment groups aims to possess the public hospitals which will be privatized in the future.

Now, as a result of the investments done to the private rather than the public field, public health expenditures showed a great increase and although, international

establishments like World Bank or IMF presses for the need of constriction in public expenses in countries, like ours, they do not avoid providing credits for the progress of liberalisation, when needed. So this situation will be continued till the system happens to be an autonomous health system. Turkey is in the process of the most rapid sectoral liberalisation which grows not with the market dynamics but with the power of law, which reminds us the time of Pinocchet in Chile.

Easing the access to the health services turned out to be an eyewash. Right, the coverage expanded but the consumption and expenses in the field of health increased rapidly. Every patient with backache has an MR scan, today and this causes a great extravagancy as to the resources, in total.

There is a dialectic process, a two-sided situation about the violation against doctors. Firstly, as to HTP, the government's language was a provocative one pointing the medical staff and we, doctors, as targets. To legitimize their changes and to create a consent producing mechanism the expressions they use were as if the society had been aggrieved and the doctors had been guilty of it. Secondly, as they claimed that the difficulties of the HTP were experienced because of the resistance of doctors, they caused a conflict between the patients and the doctors. And I think that media caused this opinion to be widespread by publishing it constantly.

Appendix C

Interviewer 1: An Academician

Integrated health campuses will be based on the private sector management mentality, though the medical personnel will be provided by the government. These campuses are established by various tenders of the private sector. Let's say, a physical medicine service will be established in this campus and let's say that we need a field of 25 square meters at least, when we consider the issue medically; nonetheless, it would be regarded as too much, when considered in terms of commerce and there would be restrictions, probably. And this may cause medical and ethical problems. This issue is ambiguous in Turkey, but i am talking about the probable situation, likely to happen, by considering the the worldwide examples. I wonder what kind of a public service will be provided under such circumstances. For example, when we look at the pictures shown to be examples, we see hospitals which are able to provide the service of a 4 or 5 star-hotel. But for whom will these hospitals serve? For whom these services will be provided? We do not know.

When public hospitals are reduced to campuses, the nearby public hospitals are most likely to be closed and be entegrated to these campuses. Thus, the nearby citizens will have to go to these entegated facilities to have the service. And also, we do not know how much the additional fees, charged by these campuses, will be. It is hard to foresee, but inevitably, we think that the situation evolves to a commoditisation process.

I observed a distinction among medical doctors: There are the ones who are unaware of the changes in general and are effected a lot by them; and also, there are the ones who work in private hospitals and think "That's none of my bussines.", inspite of being aware of the changes. As to the ones who are effected, there is a conscious section along with a silent section. I think, this situation is peculiar to Turkey only. But Turkish Medical Association (TMA) works hard on it.

The government consults specialization commission reports before making such changes, in fact. Yet, we see that the general tendency of the government is not to give place to actors who are closely involved with the changes, but it is rather to give a place to the actors who have the power of practice. For example, if you examine those reports, you will see that they take the opinion of Private Hospital Association, however they do not discuss the subject with TMA or with a professor from a university hospital.

As to the performance criterias, we say that all these entities are in the process of becoming a market place and among all the employees, the wage of a doctor happens to be higher than those of white collar employees. They have to keep those wages to a certain minimum. In fact, the first conflict between the Ministry of Health and TMA started at this point. TMA defends that the service of a doctor should be subject to a wage at humanistic living standards, instead of performance criterias and only then can the doctors work all day. In fact, TMA is the first to bring out the full-day law, forbidding doctors work in public and private hospitals or in clinics at the same time. However, the performance system, they brought is unbelievable, as %20 of it is stable, while %80 of it is subject to performance. Because, the number of the examined patients and the frequency of examinations vary according to the different branches of doctors. Today, public health specialists hardly ever examine a patient, will these doctors take the lowest wage? Do brain surgeons, eye doctors or internists examine the same number of patients? Do they need the same tests? TMA does not stand against working all day long, it stands against the full-day law and the performance system.

Here we see the discrediting of doctors, in addition to the pressure of heavy working conditions. They aim to have a more competitive environment by decreasing fees and costs.

For example, health tourism is being talked about nowadays. It did not occur till today, but they use different marketing strategies now to pull the clients, i.e. the patients in. There are campaigns like “Have your eye surgery in our hospital, be hosted at the standards of a hotel and get the chance to have an Egean Tour!”, for instance. In terms of political economy, although the government seems to be leaving the field to private sector, it gives large incentives to investment groups in health sector. From this point of view, we see that the entities on the shoreline, which are canalized to coast tourism, get the largest incentives and that means the government did not give up interfering.

I think, the private universities' medical faculties raise students for the owners of these facilities, who will employ them as they wish in the future. The marketisation and commoditization processes which have already been found in the field of education for a long time, have come into existence in the health sector. But I think that there is a two-sided situation as to the private medical faculties, parents who are able to send their

children to private schools prefer them to be doctors, for sure, i mean, there occurs the demand and so the supply is provided.

Interviewer 2: An Academician

In fact, the change, the commodification process that started in different fields of the public services progressed mainly in the field of health. To analyze any social notion, you need understand at its involvement to the system first. This requires an integral analysis process. I think, there are two variants: the accumulation of capital and the realization crisis of that. There are investment groups which make use of the accumulated capitals in different fields. Because as to production, other sectors reached their peak in our day.

There remained two fields: public services and commons. In addition, we have the case of accessibility which is stated in the texts of WB and IMF; and used as a patient satisfaction criteria. We know that to enable the private sector to provide health services, the government should make investments to the field. Health services, being provided by the public are at the private sector's agenda now. There is a great deal of trading between the local and the foreign capitals. As there is such a big flow of the private capital to the health field, the relation of the public to health services has changed. In our day, the government leaves most of the field to the private sector promptly, and in the rest of the field, prefers to profit from its services by cost minimization and performance analysis. The aim of productivity and efficiency, stated in every text of HTP affirms that.

Today, most of the public hospitals have their services by external providers and that means the connection of the public to the private in itself, which is the case for %36 of them today. In the health field, though the services are provided under the same old circumstances, people are charged with additional fees for them now. This brings the rapid commodification of health services.

Now, the providers of these services are really held under the microscope and they exist as much as their efficiency in the labour market. If a service is commodified, production conditions and suppliers of it must be standardised and this is exacty the case for the medical staff today. This caused competition among employees and bussiness oriented

hospital managements. Commodified things always experience depreciation in time. This is what the health labour power experiences now.

In fact, the increase in the number of the people covered by GHI is the demand, created to meet the supply of health services, which is commodified while it grows constantly. By GHI, the coverage has been expanded, because in a health system, subject to such a great amount of production, commodities must be covered in money, and that, we call *salto mortale*, i.e. the irony of Marx. This caused moral hazard in doctorship and general health services and doctors do not want to do their jobs anymore, as the doctor-patient relation is not like it used to be in the past. There are mainly calculations about the patients one examined in a day, now. In the past, hospitals were used to be established to meet the needs of patients, however in our day, there are hospitals which need the applications of patients indeed, this is the case exactly.

In the past, the government used to product and provide the service. Now, instead of producing, the government buys health services from the private sector on behalf of its citizens and sells these services to them again. This situation brings the government out of its context and turns it into an effective actor in the market.

The latest regulations in the fields of health and education aim to control the expectations and demands of the society, just like a military strategy. They create a mechanism of consent, as Gramsci calls it, by planning position, action, power and perception strategies for patients. In this process of the HTP, while the government increases the number of its supporters, it casts its opposers aside both in pecuniary and non-pecuniary terms and adopts an attrition policy against them. They try to adapt the producers of a service to the harsh conditions of it and to reconcile the buyers of the service to pay certain amounts.

Appendix D

Interviewer 1: New Graduate Medical Student

Far from being a social state implementation, HTP is all about privatization of the health sector. It is sad to see that it makes doctors look like enemies of the patients. Moreover, patients pay for their examinations even if they go to public hospitals, after this HTP. Although these fees are not high for now, I am sure that they will be in the future.

As for the change in the service quality of hospitals, I can say that it is just an eye-wash. They enhance the buildings, but the service quality there remains the same. It is also significant that these enhancements are provided for the medical facilities, submitting to the government.

The full-day law was to keep professors in hospitals all day long, yet it did not turn out to be so. The most qualified doctors of our universities, the most important ones as to our education went to private hospitals, unfortunately. Some departments were closed as there was not enough lecturers. Even if the access to health services got easy, I can say that this is not the case, considering these academicians.

When it comes to performance criterias, I think, they try to reduce us to tradesmen actually. In public hospitals, the examination lenght per patient is 3 minutes, while it should be 20 minutes. How ethic and idealitic can you expect the doctors to be, while there is a system in which performance points equal to money? We are forced to consider things, irrelevant to health. I am sure that the operation numbers in the private hospitals, rather than in public hospitals. Because the performance points of operations in public hospitals are absurdly low.

As for the latest incidents of violation, I can say that they happen all the time. Yet, it is obvious that they increased significantly with the HTP. Because they make us look as if we were concerned with the money, not with the patients. The patients, being the source of votes, have support of the government, thus they report every little problem or they resort to violence easily for the littlest things.

I do not think that Ministry of Health ever considers science in its policy. The only thing they aim is to reach as many patients as possible and to have as many votes as possible so. University hospitals have already lost the prestige of their names, they are just like public hospitals now.

I assume myself to be lucky, as I had my education in one of the best hospitals of Turkey. Although it was one of the best, every department had only one or two qualified lecturers, important in the medical field. Most of these qualified lecturers left university hospitals and it seems like education will worsen in the future. The government is already indifferent to this. I can not even think of other medical faculties.

I think that public university hospitals will be privatized in the long term. As the main aim of these hospitals will become profiting rather than educating, I think, education will not be so good.

Although some foundation universities have some qualified doctors from public universities, in total, we see that these are insufficient in terms of education. They raise doctors who are graduated without seeing or examining even a single patient.

Interviewer 2: New Graduate Medical Student

Doctors complain about patients, while patients complain about doctors. The situation worsens. So, I can not see any positive side of the HTP.

I believe that the service quality of university hospitals decreased. Because of physical inadequacies, patients are examined under inhuman conditions, however doctors are blamed for this and this causes them to work in a peaceless environment and hinders them from being attentive enough, I think.

Access to hospitals, medical centers, clinics etc. got easy, but I think that the access to doctors and health services, in real terms, is getting more difficult every day.

Performance system equals to the “ The more patients you examine, the more money you get.” mentality. In this equation, there is no place left for anamnesis or physical examination, the two things which were taught us to be the most important. While the quality decreases, we see that the expenses increase.

The increase of the violation against doctors is caused by a series of misinformations, which caused the society to consider doctors as money grubbing, priggish beings, and thus to assume a hostile attitude towards doctors. However, we are humanbeings too and reasoning this requires to have certain virtues...

Because of the designations of lecturers, the transfer of the qualified ones, who can give education actually, to the private sector, we raise doctors who lacks experience and knowledge. Thus, we do not have a qualified education.

Although I am relatively contended with the education, I had, I do not consider myself to be qualified enough in practice.

Only if a university is independant in terms of education and service, it is possible to do science in real terms. Only then it is possible to serve in real terms. I think, a great disappointment awaits the students in the future, as to that.

When it comes to the medical faculties established in private/foundation universities, I think, they are established for the sake of profiting. I am distrustful about the aducation and health services, given in these.

As for the integrated health campusses, I think, they will cause even more trouble for the already troubled health services, although they are claimed to be aiming a better service quality. This change is like a bolt from the blue, it has no substructure.

While I still question my choice of profession, as a doctor who experienced the feeling of being threatened, when he was still a senior student and experienced it inspite of his intention to help, it is sad to to see that also the Ministry of Health is against us...

Interviewer 3: New Graduate Medical Student

The major negativity of the HTP has been the performance system which is based on the notion of "If you pay peanuts you get monkeys.", hindering the work of doctors.

There has not been any significant improvements as to the quality of health services.

The access to health services may get easy in some cities, but I think for some cities, they just make it look so.

The increase in the number of operations and the consumption of drugs are the results of the HTP. Besides, there is an increase as to the use of diagnosis tests.

The violation against doctors has definately increased. There are lots of reasons for that, like the education level of the society, health policy of the country or precautions which were not taken in time.

As for the university hospitals' bounding to the Ministry of Health, I think, an institution needs to be independant and to have a democratic environment, if you want to do science there. However, I can not say that they did science fairly in the universities of our country also in the past.

The education we have is good in theory, but mediocre in practice.

I think, all the publicly owned university hospitals will be privatized in the long term. And this will effect medical education negatively, for sure.

When it comes to the rapid increase in the number of the medical faculties established in private/foundation universities, I think that they try to cheapen the work of doctors by increasing their number in the country. However, as it is done in every field our country, these faculties are established without setting up a proper substructure first, thus you can not expect them to work out. My personal opinion is that all the medical students of private universities should have full scholarship.

The authorization for procurance of medicines and other supplies, along with the public health auctions is given to a single institution. Still, when I consider the vastness of the sector, I think that there are surely some seeking for the rent from this sector.

Appendix E

Interviewer 1: Assistant Doctor in A University Hospital

It may sound good, however it brought an unnecessary work load to the third step institutions like university hospitals, as the referral chain system was abrogated and the hospitals were made into places where everybody may come in, anytime he wishes. Patients who can be cured in any periphery health facility easily appeal to the top step facilities, so the patients who really need to go to these hospitals can not benefit from the service because of the crowd. The performance system and the law known to be "full-day law", these are all repetitions of what they tried to do before. Taking a step unless the essential background is provided causes some problems whose results we will witness more clearly in the long term.

To increase the quality of a system, you should increase the quality of all its steps. University hospitals are trying to stand on their own feet, at the present time. While problems like inadequacies of the technical infrastructure, quality of materials and buildings are left untouched, trying to increase the service quality by keeping the personnel in hospitals is just like using fly spray on marshes. With the full-day law, many senior teachers left universities and their positions started to be filled by the newcomers who does not know what it is to be an academic member for real and work like specialists. Being not so visible for now, the results of these steps which will set medical education back in the long term will cause the rising generation of doctors to be less qualified.

In theory, everybody can appeal to any hospital or any department, he wishes. But a big group of people who act by some hearsay informations cause an extra work load, only. A patient with constipation complaint appeals to a university hospital instead of a village clinic, for example.

Performace criterias are designated differently for every department. As to my clinic, i should say that operations like appendicectomy, hernioplasty, circumcision or undescended testicle surgeries which are relatively easy and do not need a hospitalisation process, so which can be performed many times in a day are done in periphery facilities now. Because they provide a significant contribution to the performance. Instead of dealing with a tumour surgery all day long, suffering from its stress, retracing the intensive care and service processes for days and bearing all these

for a nominal fee; performing lots of operations in the same time, with less stress and more performance points attracts lots of doctors.

Rather than the increase of violence, we can say that people do not respect doctors or medical staff as much as they did in the past. As the government points individuals as a target to hide its inadequacies and media makes sensational news without searching for the truth of a matter; and because of the appointments done for the sake of votes, the situation is provoked more. But we should also indicate that as it happens in all professions, there are some doctors who misuse their authority.

Each of them has become dependant institutions. I think that rather than scientific activities, there will be patient care and daily treatment practices, only.

Compared to foreign ones, as an assistant, the theoretic education, I am having is worse but as to practice, I am having a quite good education.

Probably, their points will decrease in time and maybe, they will have to put an end to educating students.

As I witnessed the inadequacy of their qualities during my studentship, I believe that there should not be any private medical faculties.

It is inspired by foreign models but even the guidelines are not clear for now. It seems to be brought up without any careful consideration or planning. Trying to hide the inadequacies by linking up the hospitals will bring both positive and negative results.

Interviewer 2: Assistant Doctor in A University Hospital

Health services must be provided by the government. I see that HTP is all about privatization. This is wrong, I think. I see that the medical staff is also not pleased with this program.

Considering working hours of the medical personnel, the number of patients per personnel, working conditions and physical conditions, I can say that the change in the quality of the health services is a negative one.

Access to health services got easy.

I think, performance system should not be in the health services. The increase in the number of operations and the consumption of meds is a result of the HTP.

Because of the health policies, the society respects less and trusts less to the doctors. A bad image was created as to doctors and that brought violence. Security measures are

not enough and this is also a reason. In addition, there are not any sanctions, defined by law for these violence acts, so there is nothing deterrent about them. Doctors are defenseless in every respect.

As for the bounding of the university hospitals to the Ministry of Health, I think it turns them into hospitals in which have no values, science is made nothing of and profiting is the sole aim.

I think, the education I am having is not enough. This is because there is not a good education system. Self improvement is based entirely on the personal effort.

Health policies are changing constantly, thus it is hard to foresee. Turkey is a successful country in terms of medicine. We raise worthy doctors under hard conditions and it will continue.

Doctorship requires a very special education. To establish a private or public medical faculty, you should have enough lecturers and hospital equipments. I think, the quality of health services and education provided in these new medical faculties are not sufficient yet.

I do not know much about integrated health facilities, so i will not present an opinion as to that.

Appendix F

Interviewer 1: Doctor Who Owns Medical Center

If we consider the situation in terms of small-sized enterprises, before the program, private hospitals used to provide a more qualified service than public hospitals for the ones who do not prefer to have public hospitals' service. After HTP, thanks to the SSI agreement, the number of patients applying to private hospitals increase, thus the examination length spared for each patient shortened, for sure. In addition, as the fees paid by SSI per patient are too low, these hospitals tried to cope with this problem by increasing the number of examinations, they make. So this caused a decrease in the service quality, patient satisfaction and professional contentment of doctors.

I think, it was right to bring together Social Insurance Institution, Pension Fund and Bağ-Kur under the same roof of SSI. On the other hand, ministry of health which used to be in the position of the serving, began to control SSI. This means the monopolization of all the providing, buying and selling works of services. So, the Ministry of Health becomes both the controller and the rival of small and middle sized enterprises, while there is no institution to control it. There are lots of public hospitals which are under the standards of medical centers and I do not even compare the village clinics. But, they misuse their power to suppress medical centers and so, they lead up to monopolization.

The access to health services got easy at the beginning, the number of the small and middle sized enterprises showed an increase. Doctors had already started to open enterprises like medical centers, branch hospitals etc. , which became a dynamic of Turkey by itself, before the HTP. This dynamic was positive as it enabled the doctors to have enterprises easily and to do their jobs better. By the monopolization quality of the HTP, ambulatory medical centers had nearly 15 regulations in the last 4 years. These were all restrictive and compulsive regulations. Later on, the number of these ambulatory medical centers decreased from 1000s to 300s, as I remember. I think, this limited the access to the health services again.

I worked in public service before the performance system. I witnessed how the doctors became unconcerned with the patients in this period. By the coming of the performance criterias, doctors started to be considered as if rivals or profit-partners. This spoiled the working peace of doctors and caused them to regard the patients as customers. Rather

than humanbeings who need to be treated, patients were regarded as a means of gaining points.

This caused occupational degeneration and effected the patient's attitude against doctors negatively. To be a good doctor, you should heal the patients in the first place, not gain points. And what is the fastest, the most economical and effective way to achieve this? The value of the art of medicine reveals itself at this point. It is not possible to cure every patient by the same tests. This means an unnecessary increase of costs and the ineffective use of sources. We should provide the maximum treatment with the minimum cost, i. e. the optimum profit.

SSI has statistics as to that, revealing the situation clearly. When a test is included in the package, the use of it decreases rapidly; however, when it is excluded from the list (that is to say, when SSI pays hospitals for it) use of the same test increases significantly. These regulations caused doctors to use their sources unnecessarily and thus, to sidetrack from the main aim of doctorship. While I was working in Bakırköy Public Hospital, SSI was paying for laboratory tests. I saw the head doctor of the hospital questioning a doctor by saying "I need to be successful and make money in this hospital. Why don't you prescribe more tests?". Later on, SSI included most of these biochemical tests in the package. So, the same head doctors began to say "Don't prescribe so many tests. It causes the hospital to make loss and when the net current assets are low, it causes my failure." All those ironic scenes were witnessed. Executives had such behavioural disorders for the sake of being "successful".

While it is possible to do your job as a doctor without losing your moral values in small-sized enterprises, as you resign yourself to the market, the possibility vanishes. In a profit oriented enterprise, you can not talk about good doctorship. It needs a great deal of individual effort and only a very small number of the enterprises do it. However, society's return to this effort is positive in long term. Because the patient sees that you regard him as a patient sooner or later.

As for health, one thinks that his problem is the most urgent one on the earth. Although you say, as a doctor, that it is not that urgent, one tends to act as he is conditioned. Violence against doctors was not so much in the past. I have studied to be specialised in general surgery for 4 years in Taksim Education and Research Hospital, one of the most dense hospitals of Turkey where the weirdest cases apply to. And I have witnessed this

kind of violation acts once or twice. I think, the government plays a provocative role for the society, deliberately. They carry out a policy, disgracing the medical staff and the doctors. This is not against only doctors, but it is against all the professions, maintained by higher education. It serves also as a kind of JDP's defense for the lower class, as JDP acts with a kind of inferiority complex and sense of revenge. Because the educated section of the society do not vote for JDP and the wealth and power of this section disturb them. They have a suppressing policy, as I see. And it is all the same for enterprises like ours, for lawyers, engineers or military officers. There is an alienating process and the doctors are first in that list.

According to the law, the owners of the small and middle sized enterprises should be doctors. During this transformation process, many enterprises were simulated to be owned by doctors and thus, possessed by big investment groups; however the Ministry of Health did nothing about it. In the process of this regulation's preparation, I went one of the meetings as a representative of the private medical facilities. The general climate of the meeting was that they would allow anybody to open these facilities. However, you can not explain the importance of a defibrator for a hospital to somebody who does not work in the health field. Only a doctor knows such a thing. We made a great effort to convince them that at least one of the partners of these facilities should be a doctor. This regulation is still in force, but it is still ignored.

They force the medical centers to choose between expanding by integrating or closing, till the end of 2013. 95% of the enterprises today can not meet the required standards. The regulation as to the selling of these enterprises to big hospitals is prepared. This means monopolisation, in short. We will either be in higher debts to expand or leave this field. I believe that we should stay and fight.

For these enterprises, it is not possible to meet their expenses by the payments of SSI. There is a big difference between the expenses of public and private enterprises. First of all, the expenses of private enterprises are high, the enterprise meet the expenses like rental fees, electric, water and gas bills, personnel wages and taxes on its own. However, as for the public enterprises, the government usually does not pay a rental fee and pays the rest from the general budget, so their expenses are low. Still, SSI pays higher fees to public hospitals than it pays to private ones. Private hospitals can profit only by the additional fees, they charge which vary from being 30% in medical centers

to be more than %100 in big private hospitals. The rate of %30 is not enough even to meet the costs of medical centers. These rates are not applicable and it is revealed by researches that many hospitals do not apply the defined rates. SSI is aware of the situation. Yet, many small sized enterprises and hospitals levy a fine on the grounds of controls and complaints.

Interviewer 2: Doctor Who Owns Medical Center

There have not been any laws about private medical facilities in Turkey on which they can be based, since the time they emerged. For the last 7 or 8 years, the health system has been carried on by constantly changing regulations. In Turkey, private health services are meant for the ones who can not have the public health services or the ones who seek for better quality. Private medical facilities like clinics, polyclinics and medical centers are not defined by law clearly, their form and content are changed by constantly changing regulations. Before this law, all those facilities were controlled by Ministry of Health. However, Ministry of Health passed its audit mandate on Social Security Institution (SSI), by new regulations. Today, all the private facilities have an agreement with the SSI and SSI keeps all these private facilities under control in terms of financing. I quitted my job the day I completed my obligatory service and then I started to work freelance, i worked neither in public nor in the private sectors. Because, I think, it is not ethical to send a patient from hospital to your private clinic. Nonetheless, when I consider the existing system, the methods I considered to be unethical and rejected before, seem to be more preferable.

By the implementation of bundle pricing, when a patient with internal disease goes to a private hospital, Social Security Institution pays a sum between 21 and 24 Liras to the hospital, depending on the hospital's charging and that includes clinic, laboratory and doctor expenses. And we are let to have only the %30 of this sum as a contribution fee. So a sum like 32 Liras is paid to the hospital and they expect us to meet all the service expenses with that 32 Liras.

The system availed to nothing but the increase of medicine consumption. We have become a society which consumes more meds. They may claim that the medicine consumption increased, because the access to the health services got easy; however, if we consider the situation in terms of obligatory drugs, we see that this is not the case.

Instead of going to a hospital and paying a 12 Lira contribution fee, the patients choose to go to a pharmacy directly and buy a 10 Lira medicine. The increase of the medicine consumption creates a society, dependant of medicine. By the introduction of family doctors' system, village clinics are made into private clinics whose wages are paid by the public sector. In addition, we hear that the representatives from private hospitals visit these family doctors and ask them to send the patients who need to be operated to their hospitals and offer them premiums for that.

More than %95 of the hospital chains have foreign partners or they belong to the foreign capital investments entirely. This is not a surprise, as health sector is very profitable. It is obvious that the public hospitals will be sold to these foreign investment groups later on.

Today, medical centers are forced to be closed and to sell their staff to private hospitals, as they are required to have some regulations which they can not have actually, in the name of enhancing physical conditions. It is said that a medical center has to have a parking area, available for a car in every 125 square metres. They set lots of conditions like "The entrance must be sepearate." or " There must not be any other foundations in the facility." For a metropolitan city like Istanbul, this is not realistic. For example, the parking issue is under the responsibility of municipalities, in Istanbul. They set the condition of having a parking area, before they give the construction permit for apartments or they build parking areas themselves for a certain price. However, municipalities do not fulfill their duties and thus, you happen to be blamed. Additionally, %70 of the buildings in this city are not constructed properly, according to the rules and conditions set in their construction permits. And the thing is, they created a climate as if the foundation was adaptable for such regulations and we hindered it.

The conditions they set for medical centers are not applicable, we need help for these. They should either change or ease the conditions. We do not know what to do, if we can fulfil the conditions, there will be no problem; however, if we can not, our medical centers will be closed or sold.

Violation against doctors existed also in the past. Especially, patient relatives tend to blame doctors in case of a problem. Doctors are humanbeings too, they can be mistaken and do malpractice, which may cause them to resort to violence. But I think, this is all about the speeches and manners of our statesmen. The more respect the politicians

show, the more respectful the society becomes. If the Prime Minister says “I don’t trust to doctors... I wouldn’t have even an injection.”, there is a clear fact about that, in Turkey, doctors are being graduated without learning to give “even an injection”. So they should either stop establishing so many medical faculties or qualify the education, given there. If the prime minister says that he would not be vaccinated against swine flu, while the minister of health tells you to be vaccinated, it means, there is a serious problem of trust.

There are two reasons for the rapid increase of private medical faculties: Firstly, they have the prestige of a university hospital and secondly, they do not encounter a staffing obstacle, while the government made things even more difficult for staffing.

As for the integrated health campuses, I think, transportation for such big facilities will cause a serious problem. This requires a transportation network which enables everybody from all corners of the city to reach there. We do not have a proper substructure for that. In our day, the number of the patients applying to Çapa and Cerrahpaşa Medical Faculties is so high that they even cause congestion, this is because these hospitals are central in the city. If you bring these hospitals outside the city, it will not be possible for the same number of people to benefit from them.

Interviewer 3: Doctor Who Owns Medical Center

Access to health services got easy, right. This led to the increase of applications made to polyclinics, however it did not change the service quality there. Medical examinations and screenings increased, but it is not possible to make the same statement in terms of health services’ quality.

It is right that there are not any standards for the additional fees, charged by hospitals, as everybody, including patients accept that it is not possible to carry on the businesses with the advised fees. Patients already consent to pay these fees, though they are illegal, to have the service. SSI is aware of that if they did their controls in the strictest sense, the system would collapse, so they try carry on by avoiding being strict. In fact, the controllers are humanbeings too and they stuck between the law and its implementation.

It is right that there is an increase of screening programs like mammography and colonoscopy. But I think that the increase in the number of operations is led by the

recording of the small operations, which were not recorded before. I think, the increase of medicine consumption is related to the increased access to health services. Yet, whether the increase of medicine consumption is good or bad is an argumentative issue. As for the violation against doctors, I think, the way the media launches it is not right. In news, expressions like wrong therapy are frequently used and that spoils the image of HTP, created in the minds of people as to provide qualified and cheap health services. Health doings are not standart, they depend not only on human physiology but also on lots of other factors, they do not depend on a sole mathematical fact.

Medical centers used to be self-sufficient enterprises, established by doctors' and their relatives' investments, their conditions and capacities were mediocre and they used to be more local in the past. However, they are forced to expand by the increase of medical workups, examinations and transactions, today. While some of the medical centres are not fitted to expand in terms of investment and feasibility, others are more open to improvement. Still, they are not able to provide the required physical conditions with their existing states. And this is acknowledged by everybody, including the Ministry of Health, in fact.

While medical centers can not profit with low additional fees, you can not expect them to make investments for expanding. I plan to close my enterprise, if I can not find myself a proper place in the new system with my existing budget, and to continue working in the field of health as an employee.

If there will be any planning, it must be done in real terms. Surely, health service facilities should have good conditions. In our day, the system works thanks to the increase of the applications and additional fees, charged by hospitals. If these additional fees were taken according to the rates defined by law, the system would never work.

When it comes to the integrated health campusses, it seems like they will be constructed as corporate health complexes and be sold or handed over to the private sector. But I am doubtful about which section of the society will they serve for.