Debating Turkish Health Reform

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The intellectual content of this dissertation, which has been written by me and for which I take full responsibility, is my own, original work, and it has not been previously or concurrently submitted elsewhere for any other examination or degree of higher education. The sources of all paraphrased and quoted materials, concepts, and ideas are fully cited, and the admissible contributions and assistance of others with respect to the conception of the work as well as to linguistic expression are explicitly acknowledged herein.

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Abstract

Debating Turkish Health Reform

Ayşecan Kartal, Doctoral Candidate at the Atatürk Institute
for Modern Turkish History at Boğaziçi University, 2019

Associate Professor Berna Yazıcı, Dissertation Advisor

This dissertation is a study of the political debate that got generated around health reform in Turkey between 2002 and 2011, which corresponds to the formative period for the debate. Through a close examination of both the pro-reform and anti-reform discourse on health, it shows how a technical issue such as health care became a primary ground of political debate, contestation and polarization in the Turkey of early 2000s.

More specifically, the AKP's pro-reform discourse and the pro-government media presented health care providers and health care receivers as opposing groups and positioned the AKP as the protector of health care receivers. This pro-reform discourse emphasized the universalist trend in the reform that abolished the inegalitarian structure of the pre-existing health system and extended coverage. On the other side of the political debate, opponents of the reform, mainly the TTB (Turkish Medical Association), highlighted the neoliberal aspects of the reform. However, the oppositional discourse did not receive wide support as it was formulated when the short term benefits introduced by the reform were still in effect.

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Özet

Türkiye'de Sağlık Reformunu Tartışmak

Ayşecan Kartal, Doktora Adayı, 2019
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Bu tez Türkiye'de sağlıkta reform etrafında 2002-2011 yılları arasında ortaya çıkan siyasi tartışma üzerine olan bir çalışmadır. 2002-2011 yılları bu siyasi tartışmanın şekillendiği dönemdir. Çalışmada reform yanlısı ve reform karşıtı söylemler derinlemesine incelenerek, sağlık gibi teknik sayılabilecek bir konunun 2000ler Türkiyesi'nde nasıl bir siyasi tartışma, muhalefet ve kutuplaşma zemini haline geldiği gösterilmiştir.

Daha belirgin bir biçimde söylenecek olursa, AKP'nin reform yanlısı söylemi ve AKP'ye yakın olan medya sağlık hizmeti sunanları ve sağlık hizmeti alanları karşıt gruplar olarak sunmakta ve AKP'yi sağlık hizmeti alanların koruyucusu olarak konumlamaktadır. Reform yanlısı söylem, reformun kapsamı arttırıcı ve önceki sistemin eşitsiz yapısını ortadan kaldıran evrensel sağlık kapsayıcılığı trendini vurgulamıştır. Siyasi tartışmanın diğer tarafında ise, başta TTB (Türk Tabipler Birliği) olmak üzere reforma muhalif olanlar, reformun neoliberal yönlerinin altını çizmişlerdir. Ancak muhalif söylem ortaya konduğu sırada reformun kısa vadeli yararları halen etkili olduğu için, reform karşıtı söylem yaygın bir destek görmemiştir.

101.000 kelime

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Anneme

Table of Contents

Acronyms *xix*
Acknowledgements *xx*

1 INTRODUCTION 1

1.1 Theoretical Literature and Contribution of the Study 8
1.2 Design of the Research 35
1.3 Dissertation Outline 37

2 GLOBAL HEALTH REFORM: SITUATING TURKISH HEALTH REFORM IN A GLOBAL CONTEXT 41

2.1 The Global Reform in Health Care 42
2.2 Typologies of Health Care Systems 48
2.3 The Turkish Health Care System and Reform in Global Context 63

3 AKP'S PROMOTION OF THE HEALTH REFORM: "DISCOURSE OF REVOLUTION IN HEALTH" 77

3.1 Claiming to put an end to people's "victimization": The discourse on patients detained in hospitals 80
3.2 Claiming to Bring Equality 88
3.3 Concluding Remarks 108

4 PRESENTING THE NOVELTIES AND ACCOMPLISHMENTS OF AN "UNPRECEDENTED REFORM" 111

4.1 Claiming Efficiency 113
4.2 Claiming Quality 142
4.3 The Discursive Emphasis on Patients' Rights 157
4.4 Concluding Remarks 159

5 THE HEALTH REFORM IN PRO-GOVERNMENT MEDIA DISCOURSE: PITTING PROVIDERS AGAINST RECEIVERS 161

5.1 Portraying the pre-AKP Health System: A system that victimizes the people 163
5.2 Portraying Health Reform as a Fight against Corruption 167
5.3 Portraying Doctors as Self-interest Driven Actors 171
5.4 Dismissing the anti-Health Transformation Program Actors and Discourses 177
5.5 "Celebrating" The Reform and Novelties of the New Health Care System 182
5.6 Concluding Remarks 188

6 WHO ARE THE CONTESTERS? 191

6.1 Overview of the Actors: The Turkish Medical Association and Other Actors 193
6.2 Responses of the Contesters to the HTP 200
6.3 How do the Contesting Actors Differentiate and evaluate themselves? 206
6.4 How do the contesting actors evaluate the Health Transformation Program? 214
6.5 How do the Contesting Actors Justify the Strikes and Demonstrations? 221
6.6 Concluding Remarks 228

7 CONTESTING THE PRIVATIZATION AND COMMODIFICATION OF HEALTH SERVICES 231

7.1 Transfer of SSK Hospitals 233
7.2 Public Hospital Unions (*Kamu Hastane Birlikleri*) 241
7.3 The State Budget and Health 247
7.4 Concluding Remarks 255

8 HIGHLIGHTING THE HTP'S NEGATIVE IMPACTS ON HEALTH CARE PROVIDERS AND HEALTH CARE RECEIVERS 257

8.1 Concerns over Citizens' Right to Health 258
8.2 Working Conditions of Doctors and Health Personnel 266
8.3 Concluding Remarks 290

9 CONCLUSION 293

APPENDICES 307

A Chronology of HTP 307
B List of Interviewees 311
C Quotations in Original Language 313

BIBLIOGRAPHY 373

Acronyms

AKP	Adalet ve Kalkınma Partisi (Justice and Development Party)
BAĞ-KUR	Esnaf ve Santakarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu (Independent Workers Insurance Institution)
CHP	Cumhuriyet Halk Partisi (Republican People's Party)
Dev-Sağlık-İŞ	Devrimci Sağlık İşçileri Sendikası (Revolutionary Health Workers Union)
DİSK	Devrimci İşçi Sendikaları Konfederasyonu (Confederation of Progressive Trade Unions)
HAK-İŞ	Hak İşçi Sendikaları Konfederasyonu (Confederation of 'Justice Seekers' Trade Unions)
IMF	International Monetary Fund
KESK	Kamu Emekçileri Sendikaları Konfederasyonu (Confederation of Public Employees Trade Unions)
SES	Sağlık ve Sosyal Hizmet Emekçileri Sendikası (Health and Social Workers Union)
SGK	Sosyal Güvenlik Kurumu (Social Security Institution)
SSK	Sosyal Sigortalar Kurumu (Social Insurance Institution)
TDB	Türk Dişhekimleri Birliği (Turkish Dental Association)
TEB	Türk Eczacıları Birliği (Turkish Pharmacists Association)
TBMM	Türkiye Büyük Millet Meclisi (Grand National Assembly of Turkey)
TTB	Türk Tabipler Birliği (Turkish Medical Association)
TÜRK-İŞ	Türkiye İşçi Sendikaları Konfederasyonu (Confederation of Turkish Trade Unions)
WB	World Bank
WHO	World Health Organization

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1

Introduction

We have brought about a revolution in the health sector in every sense. We abolished the unhealthy bureaucracy that was causing our citizens' health to fail. We ended the differences among SSK, Bağ-Kur, and Emekli Sandığı; all the health institutions are now under the same roof. No more citizens are rejected from or detained in hospitals. We broadened the coverage of Green Card holders as well.[1]

The practice of being detained in hospitals is over. If I receive a denunciation about this, the first thing I will do is detain that doctor, detain that mentality. Because I believe that this practice is imposed on our doctors by a wrong mentality. From now on, no doctor will resort to such a solution. By preventing this, we are making a step to protect our doctors from contradicting their Hippocratic oath.[2]

---

1 "Sağlıkta Tam Anlamıyla Bir Devrim Yaptık," *Türkiye Bülteni,* June 9, 2011, http://www.turkiyebulteni.org/PDF/70%20TB%20MAYIS%20HAZIRAN.pdf. (See appendix C.1 for the original.)

2 Statement by Recep Tayyip Erdoğan during the opening ceremony of Ümraniye State Hospital. "Hastanede Rehin Devri Bitti," *Yeni Şafak,* March 17, 2004. (See appendix C.2 for the original.)

> *We started a transformation in health. We made revolutionary steps in 112 emergency services which come to the rescue of our citizens. We increased the number of ambulances from 617 in 2002 to 2,547 in 2011 in order to reach our patients even in difficult conditions. We put eighteen helicopters, two plane ambulances, four sea ambulances, and 132 snow pallet ambulances into service in Turkey. It was a dream but it has become reality.*[3]

All these statements, analyzed in detail in the following chapters, exemplify the political discourse that the Justice and Development Party (Adalet ve Kalkınma Partisi, or AKP) employed to present and support the Health Transformation Program (HTP)- reform to health care- it initiated in 2003 soon after coming to power.

Health care was a primary issue on the agenda from the first days of AKP governance. Following the establishment of the first AKP government on 19 November 2002, the first circular of the AKP Government was published by the Ministry of Health on the issue of detaining patients in hospitals.[4] The circular was communicated to all governorships of the eighty-one provinces country-wide and stated that

> as there are cases where patients, babies, mothers, and the bodies of the deceased are detained for the reason they have not paid the fees for the services they received at the hospital, from now on no patient or

3 "AK Parti'nin 3. Sağlık Reklam Filmi -Hayaldi Gerçek Oldu," YouTube video, 0:55, posted anonymously, May 22, 2011, https://www.youtube.com/watch?v=lExH90P4mQc.

4 The issue of patients detained in hospitals was a frequent news item on the evening news and in newspapers of the 1990s. If patients without social security coverage was unable to pay after the completion of their treatment, the hospital administration could refuse to discharge them or release a burial certificate for a funeral. This practice of blocking discharges was commonly referred to as being "detained," or "held captive."

> body of a deceased person will be detained in hospitals on the justification of the nonpayment of fees.[5]

The Minister of Health, Recep Akdağ, immediately made his public statement on the issue: "The necessary legal measures will be taken against hospital administrators who do not act in accordance with this circular by the authorization given to our ministry"[6]

That the first circular from the Ministry of Health under the first AKP government was on the regulation of patient discharges was not coincidental. It was a sign that health would become a politically significant area for the AKP to construct and strengthen its broader populist discourse in the coming years.

This dissertation first examines the political discourse generated by the AKP and pro-government media around health care reform, focusing on a period from November 2002 until the 12 June 2011 parliamentary elections, which corresponds to the formative period for political discourse and debate on health reform.[7] It particularly highlights the way the topic of health reform figured predominantly in the electoral campaign periods in 2004 and 2009 local elections and 2007 and 2011 parliamentary elections.

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5 "25521-2002/119 sayılı Taburcu İşlemleri Hakkında Genelge," 2November 26, 2002 "Circular no: 25521-2002/119 on Discharge Procedures" http://www.istanbul-saglik.gov.tr/w/mev/mev_gen/tedavi_hiz/taburcu_islemleri_Hakkinda_Genelge.pdf. (See appendix C.3 for the original.)

6 "Aksine hareket eden kurum yöneticileri ve sorumluları hakkında ilgili mevzuat uyarınca bakanlığımıza tanınan yetkiler çerçevesinde gerekli kanuni işlemlerin yapılacağını duyurdu." "Hastalar Rehin Tutulmayacak," NTV, 27 November 2002, http://arsiv.ntv.com.tr/news/189894.asp

7 There are two reasons why the research is limited to the debate before 2011. First, the health transformation program is ongoing, and for the feasibility of the research some limit was necessary. Secondly, even if not fully finalized, all the legal processes regarding changes enlisted in the HTP began prior to 2011. Furthermore, this dissertation does not analyze the impacts of health reform but rather examines how health worked as an area where the greater populist narrative of AKP as well as an oppositional political discourse on health reform were materialized. Thus, it was important to examine the formative period of this political debate on health reform, regardless of whether the legislation in some specific issues (such full-time employment and obligatory service for doctors) were finalized.

The main research question of the dissertation is: How and why the health reform debate became a key site of construction of AKP's populist politics that rests on construction of a "New Turkey" - where the inequalities created by the elites are claimed to be abolished- despite the commodifying and inegalitarian outcomes of the health reform? The sub research questions asked for tracing the main question are: How did the AKP discourse present and justify reform in health care? How is the narrative of the AKP's success reflected in electoral campaigns through health? In what ways did the broader populist politics and discourse of the AKP materialize in its specific discourse on health care reform? How were the main themes of populist politics (such as anti-elitism and serving the people) reflected in the AKP's discourse on health care reform? How was the opposition movement shaped? What were the main arguments of the opposing actors? How did the oppositional discourse stand and to what extent was it effective vis-à-vis the AKP's pro-reform discourse?

In sum, this dissertation is a study of the political debate that got generated around health reform in Turkey between 2002 and 2011. Through providing a close examination of both the pro-reform and anti-reform discourse on health, it shows how a technical issue such as health care became a primary ground of political debate, contestation and polarization in the Turkey of early 2000s. This study demonstrates how populist politics is built through health and how the populism is practiced through both presentation and execution of the health reform.

This dissertation argues and demonstrates that the health reform in Turkey despite its neoliberal outcomes and agendas and resulting in commodification and privatization of health services has been embraced by the majority of the public as it has been packaged with a coherent populist framing. The health care is constructed as a key site of the AKP's populist politics. The dissertation also argues that, as the opponents base their objections and criticisms to this reform on the long-term consequences of the health care reform their discourse remains less strong in the face of the short term gains of the health care reform. In other words the two sides of this debate construct their arguments on different temporalities, while the government's arguments – a

characteristic of populist politics- reflect the short term immediate-to-experience, concrete consequences of the health-care reform, the ones of the opponents remain abstract and less convincing than that of the government.

In the AKP's populist discourse, serving the people, treating all citizens as equal, being just, representing a radically different approach from previous governments, and the claiming to introduce a total change of mentality in the country emerge as central themes. This populist politics rests on a discursive opposition constructed between the "Old Turkey" where the AKP claims the citizens were victimized by the elites and the "New Turkey" which the AKP offers to construct on the basis of equality.

Day-to-day issues such as health and transformation are areas through which the populist politics are constructed as the short-term consequences of those issues are compatible with the short-term result oriented agenda of populist politics. This study will look at how the populist politics of AKP is constructed through health reform. In this broader political picture, health care emerged as a key discursive space where the AKP's populist claims to end "Old Turkey's" social inequalities and "victimizations" materialized. Furthermore, the AKP's changes to the health care system were presented as steps that symbolized the creation of a "New Turkey" where previously victimized people are saved from privileged elites.

In other words, it was not only structural changes that the AKP insistently aimed to introduce into the health system through the HTP but also a strong discursive determinacy to propagate these changes as the end of the inequalities of "Old Turkey" that created a rupture in Turkey's larger political field. That larger political field is defined both by the AKP's populist politics as well as a contestation of this populism, as is reflected in public debate on health care reform. The fact that health care became such a highly-political issue can perhaps partially be explained by the fact that it touches the lives of all citizens and hence is a tangible area and daily concern for most.

As the following chapters demonstrate, the AKP presented its health care reform as an "unprecedented reform" in Turkey's history. It claimed to be different from contemporary political actors (in and out of parliament) in terms of recognizing the problems of the Turkish health system, and making steps

to resolve them. More specifically, as exemplified in one of the opening quotations, the AKP framed its changes to the health system as a "revolution in health." The "revolution in health" discourse of the AKP promised an equality not enjoyed in pre-AKP periods and projected an image of a government that sides with the people. These claims were constructed around specific issues regarding health care that will be examined in the following chapters. A word of caution however is necessary here, as the health reform in Turkey and the way it is embraced is not only a result of the populist framing. There is an increase of access and coverage which is a direct result of health care reforms that abolished the inegalitarian structure of the health care system in the pre-reform period which is the subject of Chapter 2.

Most importantly, this dissertation argues that the AKP's pro-reform discourse presented health care providers and health care receivers as opposing groups and positioned the AKP as the protector of health care receivers who had not received the services they deserved in the pre-AKP period. This discourse claims that health care receivers were deprived of the services they deserved mainly because health care providers (equated with doctors), like the country's other elites, prioritized the protection of their own interests rather than "serving" the people. Pro-government media coverage of health reform complemented and reinforced the AKP's political discourse on health reform.

On the other side of the political debate, opponents of changes taking place in the health sector, mainly the TTB, highlighted the neoliberal aspects of health policy reform. The main opposition to the HTP came from the TTB through organized strikes, demonstrations, and court cases aimed at striking down certain laws. As discussed in Chapter 6, the peculiar organizational character of the TTB is crucial for understanding the ways it reacted and responded to and criticized the HTP. It is possible to argue that the characteristics of the TTB are different from a professional association that solely protects its professional boundaries and defines the ways in which the profession can be exercised.

This opposition and criticism from the TTB was based on the protection of the professional rights of doctors and the rights of the people to health. Their main concern was the privatization of health-care services in the long run as a consequence of the health policy reforms. They argued that health-

care receivers would experience a loss of rights in the long run, and the personal benefits and working conditions for health-care providers would be impacted negatively.

However, the oppositional discourse did not receive wide support as a consequence of the strong and coherent, populist narrative of the AKP. This also had to do with the nature of the political contestation of the reform which was limited to service providers and not voiced by service receivers. Even though service providers stressed in their discourses that their concern was not only their own interests, the absence of a strong voice from patients strengthened the discourse of the government that positioned service providers as a group that cared only for their own interests and opposed health reform for their own material benefits at the expense of better service.

Moreover, the oppositional discourse was formulated when the short term benefits introduced by the HTP were still in effect and long term consequences had not yet crystallized. Thus the government's pro-reform discourse had "concrete", "visible" consequences unlike to the discourses of the contesting actors. As discussed in Chapter 2, the limited data on the reception suggests that health care reform was popular among receivers, which can be explained by the short-term satisfaction it generated.

A related explanation concerns the dual trend of health reform, as discussed in Chapter 2. On one hand, there has been a universalist trend in health reform that both abolished the inegalitarian structure of the existing health system and extend coverage. On the other, there was a move to introduce marketization and alter the role of the state in the health system. As the dissertation demonstrates the AKP along with pro-government media foregrounded the first of these trends in building its discourse on health reform and in its larger populist politics. The oppositional discourse, on the other hand, highlighted the second -the marketization introduced into the system.

In the end, the split between receivers versus providers prevailed in the public debate on health reform. The discursive opposition constructed between the citizen-receivers and doctor-providers took a turn and became more dominant when the Full Time Employment Law (Chapter 8) came onto the agenda in 2010, introducing restrictions on the working arrangements of doctors in the public sector. With this on the agenda, public debate around

health reform, which concerned a major restructuring with consequences for an entire population, was framed more boldly as a struggle between the government and contesting actors, mostly doctors represented by the TTB.

§ 1.1 Theoretical Literature and Contribution of the Study

The focus of this study is not the dynamics of the policy formulation of health reform or its consequences. Rather, it uses the political debate on health reform as an analytical lens through which to explain the populist narrative and politics of AKP as well as how political polarization emerged as a consequence. The study seeks to understand how a health reform with neoliberal consequences such as privatization and commodification was widely embraced by the public. Thus, the study contributes to scholarly debates on the populism of the AKP and the political polarization of Turkey in the 2000s. The dissertation also contributes to the sophisticated analyses on health reform in Turkey by highlighting the political dimension of health reform.

The following sections discuss two main academic literatures: the social science literature on populism- along with specific analyses of the AKP's populism- and studies of Turkish health reform.

1.1.1 *Populism*

Social scientists, political scientists, and sociologists have used the term populism frequently in the last two decades. Its wide usage for explaining diverse political contexts has triggered discussions over its definition. The frequent usage of the term in the media to explain political currents in various regions of the world has blurred the concept further. Its different connotations depend on context- such as right-wing and anti-immigration parties in Europe and left-wing parties in Latin America- which according to Mudde and Kaltwasser, led to a discussion centered not only on what it is but on whether it exists.[8]

Discussions over the definition of the term led some scholars to introduce categorizations of the literatures using the concept. Gidron and Bonikowski

8 Cas Mudde and C. Kaltwasser, *Populism: A very Short Introduction* (Oxford: Oxford University Press, 2017), 2.

divide studies that use the concept of populism as a main tool of analysis into three: populism as an ideology, as a discourse, and as a political strategy. For those that see it as an ideology, of which Mudde's work is among the most influential, populism is

> first and foremost a set of ideas characterized by an antagonism between the people and the elite, as well as the primacy of popular sovereignty, whereby the virtuous general will is placed in opposition to the moral corruption of elite actors.[9]

Scholars that see it as a discursive style, on the other hand, regard populism as a "rhetoric that constructs politics as the moral and ethical struggle between the el pueblo and the oligarchy."[10]

This approach regards populism as a political strategy that they analyze through policy changes, political organization and forms of mobilization.[11] This approach is frequently observed in the works of sociologists and political scientists that work on Latin America. Madrid defines populism

"as those aiming at economic redistribution and the nationalization of natural resources, and populist mobilization as consisting of antiestablishment and anti-system appeals."[12]

While these three approaches overlap in terms of having an elite and anti-elite divide at their core, as Gidron and Bonikowski mention, they differ from

9 Noam Gidron and Bart Banikowski, *Varieties of Populism: Literature Review and Research Agenda,* (working paper 13-4 Weatherhead Center for International Affairs, Harvard University, Cambridge, MA, 2013), 6.

10 Carlos De La Torre, *Populist Seduction in Latin America*, (Athens, OH: Ohio University Press, 2000), 4 cited in Noam Gidron and Bart Banikowski, *Varieties of Populism: Literature Review and Research Agenda,* (working paper 13-4 Weatherhead Center for International Affairs, Harvard University, Cambridge, MA, 2013), 8.

11 Noam Gidron and Bart Banikowski, *Varieties of Populism: Literature Review and Research Agenda,* (working paper 13-4 Weatherhead Center for International Affairs, Harvard University, Cambridge, MA, 2013), 10.

12 Raul Madrid, "Rise of Ethnopopulism in Latin America," *World Politics* 60, no. 3 (2008): 482; cited in Noam Gidron and Bart Banikowski, *Varieties of Populism: Literature Review and Research Agenda,* (working paper 13-4 Weatherhead Center for International Affairs, Harvard University, Cambridge, MA, 2013), 11.

each other through the methodologies they use, their scope, the scale of the region they study, and the period they analyze.

The approach to populism from an ideational perspective considers it as a world-view and makes it embrace the discursive and political strategy approaches. Thus, I found it to be a suitable conceptual departure for the discussions taking place in this research.

Mudde and Kaltwasser, whose studies focus on European right-wing parties and Latin America, regard populism from an ideational perspective and offer a definition to clarify the boundaries of the concept.

> A thin-centered ideology that considers society to be ultimately separated into two homogenous and antagonistic camps "the pure people" versus the "corrupt elite" and which argues that the politics should be an expression of the volonté général (general will) of the people.[13]

Mudde's definition of the concept as a thin-centered ideology allowed him to define it as an ideology that can be used as a framework to explain divergent political contexts in different time periods. He states that
"as a thin-centered ideology populism can easily be combined with very different (thin and full) other ideologies, including communism, ecologism, nationalism and socialism."[14]

Mudde places his definition within the ideational approach, thus considering the concept of populism as a world view. In their co-authored work with Kaltwasser, they differentiated the ideational approach from the popular agency approach, the Laclauan approach, the socioeconomic approach, the political strategy approach and the folkloric style of politics approach.[15]

The key features of populism according to Mudde and Kaltwasser are the people, the elite, and the general will. The people in the populist ideology is a combination of the people as sovereign, the common people, and the people

13 Cas Mudde and C. Kaltwasser, *Populism: A Very Short Introduction* (Oxford: Oxford University Press, 2017), 5. Same definition was made by Mudde in his article Cas Mudde, "Populist Zeitgeist," *Government and Opposition* 39, no. 4, (2004): 543.

14 Cas Mudde, "Populist Zeitgeist," *Government and Opposition* 39, no.4, (2004): 544.

15 Cas Mudde and C. Kaltwasser, *Populism: A Very Short Introduction* (Oxford: Oxford University Press, 2017), 4.

as a nation. The elite are positioned as the corrupt and opposite the pure people; the antagonism between the people and the elite rooted in from political power, socioeconomic status, and nationality. As for the elites, the main distinction between them and the people emerges on the basis of morality. The economic, political, and cultural elite are portrayed as a collective block that stands as an obstacle to the general will. While the main differences between the people and the elite concern morality, the secondary features upon which these differences in morality are based differs depending on context according to Mudde and Kaltwasser.[16] The general will, on the other hand, is

> based on the notion of 'common sense' … it is framed in a particular way, which is useful for both aggregating different demands and identifying a common enemy. By appealing to the 'general will' of the people, populism enacts a specific logic of articulation, which enables the formation of a popular subject with a strong identity ("the people"), which is able to challenge the status quo ("the elite").[17]

Stanley is among the scholars who contribute to the discussion over whether populism is an ideology, even if it is considered to be a "thin" one. He argues that the concepts that make up populism interact as an ideology. His elaboration on why it stands as a thin ideology explains how it became a frequently used concept for analyzing diverse regions of the world with diverse political, economic, and social histories.

> Populism should be regarded as a distinct ideology in that it conveys a particular way of construing the political in the specific interaction of its core concepts. However its thin nature means that it is unable to stand alone as a practical political ideology: it lacks the capacity to put forward a wide-ranging and coherent program for the solution to crucial political questions.[18]

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16 These contexts may be defined by xenophobic, anti-immigrant discourses, secularism, etc.

17 Cas Mudde and C. Kaltwasser, *Populism: A Very Short Introduction* (Oxford: Oxford University Press, 2017), 18.

18 Ben Stanley, "The thin-ideology of Populism," *Journal of Political Ideologies* 13, no.1 (2008): 95, https://doi.org/10.1080/13569310701822289.

As they do not limit it to a particular policy-making or political strategy, defining populism as a political project or a thin-ideology allows scholars to justify how it cross cuts different time-periods and geographies

Even though populism has become a widely employed conceptual tool, some regions are more prominent in the literature. Studies that focus on Latin American politics in the 1980s and 1990s look at the ways in which neoliberal policies were compatible with populist discourses of leaders such as Hugo Chavez, Carlos Menem, Alberto Fujimori, Abdala Bucaram, Carlos Salinas, and Luiz Inacio da Silva.[19]

19 Kurt Weyland, "Clarifying a Contested Subject: Populism in the Study of Latin American Politics," *Comparative Politics* 34, no. 1 (October 2001): 1-22, https://doi.org/10.2307/422412; Kurt Weyland, *Democracy without Equity: Failures of Reform in Brazil*, (Pittsburg: University of Pittsburg Press, 1996); Kurt Weyland, "The Politics of Corruption in Latin America," *Journal of Democracy* 9, no. 2 (1998): 108-121; Kurt Weyland, "Latin America's Authoritarian Drift: The Threat from the Populist Left," *Journal of Democracy* 24, no. 3 (July 2013): 18-32; Steve Ellner, "Hugo Chávez's First Decade in Office: Breakthroughs and Shortcomings," *Latin American Perspectives* 37, no. 1 (February 3, 2010): 77-96; Victor Armony, "Is there an Ideological Link between Neopopulism and Neoliberalism?" *Brazilian Journal of Political Economy* 21, no. 2 (2001): 62-77; Bruce Kay, "Fujipopulism and the Liberal State in Peru, 1990-1995," *Journal of Interamerican Studies and World Affairs* 38, no. 4 (1996): 55-98; Kenneth Roberts, "Neoliberalism and the Transformation of Populism in Latin America: The Peruvian Case," *World Politics* 48, no.1 (October 1995): 82-116; Carlos de la Torre, *Populist Seduction in Latin America: The Ecuadorian Experience* (Athens, OH: Ohio University Center for International Studies, 2000); D. Dresser, *Neopopulist Solutions to Neoliberal Problems* (San Diego, CA: University of California, Center for US- Mexican Studies, 1991); Francisco de Oliveira, "Lula in the Labyrinth," *New Left Review* 42 (November- December 2006): 5-22; Alan Knight, "Populism and Neopopulism in Latin America, Especially Mexico," *Journal of Latin American Studies* 30, no. 2 (May 1998): 223-248, https://www.jstor.org/stable/158525; Armando Boito, "Class Relations in Brazil's New Neoliberal Phase," *Latin American Perspectives* 34, no. 5 (September 2007): 115-131; Jennifer Collins, "New Left Experiences in Bolivia and Ecuador and the Challenge to Theories of Populism," *Journal of Latin American Studies* 46, no. 1 (19 February 2014): 59-86; Steven Levitsky and James Loxton, "Populism and Competitive Authoritarianism in the Andes," *Democratization* 20, no. 1 (July 2012): 107-136; Francisco Panizza and Romina Miorelli, "Populism and Democracy in Latin America," *Ethics & International Affairs* 23, no. 1 (Spring 2009): 39-46; Dani Filc, "Post-populism: Explaining Neo-liberal Populism through the Habitus," *Journal of Political Ideologies* 16, no. 2 (June 16, 2011): 221-238; Karen L. Remmer, "The Rise of Leftist– Populist Governance in Latin America: The Roots of Electoral Change,"

Despite the convergence of the themes that emerge in studies of populism from the late 1980s onwards – the elite versus the people and protecting the people from the corrupt elite and their rule-, the concept of populism in the literature evolved into neopopulism or neoliberal populism. This is especially evident in scholarly works devoted to analyzing Latin America in the last two decades in a concern to differentiate the populism of the 1990s from the one that emerged in the ISI (Import Substition Industrialization) era, in order to underscore the coexistence of neoliberal policies and the lower-class, blue-collar electoral constituencies of populist parties.

The populism - neopopulism divide in scholarly works emerged as a way to differentiate post 1980s populism from the populism of the 1930s and the ISI (Import Substitution Industrialization) period. The main source of the difference that emerged is the differing economic contexts that define these periods. Kurt Weyland lays out this difference and the need for a new conceptualization.

> Scholars used to associate populism with nationalist inward-looking economic policies, which flourished during the "easy" stage of import substitution industrialization from the 1930s to 1950s. Yet the resurgence of populism in the 1980s contradicted this argument, and the recent coincidence of political populism and economic liberalism contradicted it further.[20]

He reaches the conclusion at the end of his discussion of Latin America and Eastern Europe that

Comparative Political Studies 45, no. 8 (December 8, 2011): 947-972; Robert Barr, "The Persistence of Neopopulism in Peru? From Fujimori to Toledo," *Third World Quarterly* 24, no. 6 (December 2003): 1161-1178. https://www.jstor.org/stable/3993448; Carlos de la Torre, "The Resurgence of Radical Populism in Latin America," *Constellations* 14, no. 3 (September 2007): 384-397.

20 Kurt Weyland, "Neoliberal Populism in Latin America and Eastern Europe," *Comparative Politics* 31, no.4 (1999): 379, https://www.jstor.org/stable/422236.

> especially in fluid inchoate party systems, populism facilitates market reform, which in turn allows populist presidents to boost their leadership. Thus in countries suffering from institutional fragmentation and deep economic crises, political populism and economic liberalism can reinforce each other.[21]

This divide between the "populisms" emerge also in the work Armando Boito on Brazil where he classifies the ISI period populism as reformist populism and the "new populism" as regressive populism. He argues that while the reformist one pointed to foreign capital and the United States as enemies and aimed at expanding the Brazil's industrialization and labor rights, the regressive populism points to bureaucratic elite and the members of the congress as enemies. The regressive populism unlike the reformist one does not want to break up the ties with international financial capital, conversely works in line with it.[22]

Studies such as Weyland's[23] look at the political contexts of Brazil, Argentina, and Peru in the 1990s to explain the convergence of their experiences in

21 Ibid., 397.

22 Armando Boito, "Class Relations in Brazil's New Neoliberal Phase," *Latin American Perspectives* 156, no.5 (September 2017): 126-127.

23 Kurt Weyland, "Clarifying a Contested Subject: Populism in the Study of Latin American Politics," *Comparative Politics* 34, no. 1 (October 2001): 1-22, https://doi.org/10.2307/422412; Kurt Weyland, "Swallowing the Bitter Pill: Sources of Popular Support for Neoliberal Reform in Latin America," *Comparative Political Studies* 31, no. 5 (1998): 539-568, https://doi.org/10.1177/0010414098031005001; Kurt Weyland, "Neopopulism and Neoliberalism in Latin America," *Studies in Comparative International Development* 31, no.3 (Fall 1996): 3-31, https://doi.org/10.1007/BF0273898.

terms of populism; Roberts',[24] Barr's,[25] and Kay's[26] through the policies of Fujimori and Toledo in Peru; and Knight's[27] through the Mexican experience ,which explains how parties embracing neoliberal policies could at the same time strongly appeal to the lower classes despite the fact that their policies oppose the interests of this major section of their electoral support. Before going into that it is necessary to have a look at Kenneth Roberts' classification of different approaches to populism based on the same region (Latin America) by and the core components of populism he synthesized from those different approaches.

Roberts identifies four perspectives in the literature on populism in Latin America, namely a historical, sociological perspective that focuses on multiclass coalitions that took place in the ISI period, an economic perspective that reduces populism to redistributive policies, an ideological perspective that links populism with the discourse of contradiction between the people and the elite, and lastly, a political perspective that equates populism with the mobilization of the people through personalist leaders.[28] Roberts came up with five common components of populism to perform a comparative analysis of these different perspectives:

> 1- A personalistic and paternalistic, though not necessarily charismatic, pattern of political leadership; 2- a heterogeneous , multiclass political coalition concentrated in subaltern sectors of society; 3- a top down process of political mobilization that either bypasses institution-

24 Kenneth M. Roberts, "Neoliberalism and Transformation of Populism in Latin America: The Peruvian Case," *World Politics* 48, no. 1 (1995): 82-116, https://doi.org/10.1353/wp.1995.0004.

25 Robert Barr, "The Persistence of Neopopulism in Peru? From Fujimori to Toledo," *Third World Quarterly* 24, no. 6 (2003): 1161-1178, https://doi.org/10.1080/01436590310001630116.

26 Bruce Kay, "'Fujipopulism' and the Liberal State in Peru (1990-1995)," *Journal of Interamerican Studies and World Affairs* 38, no. 4 (Winter 1996): 55-98, https://doi.org/10.2307/166259.

27 Alan Knight, "Populism and Neopopulism in Latin America, Especially Mexico," *Journal of Latin American Studies* 30, no.2 (May 1998): 223-248, https://www.jstor.org/stable/158525.

28 Kenneth M. Roberts, "Neoliberalism and Transformation of Populism in Latin America: The Peruvian Case," *World Politics* 48, no.1 (1995): 84-85, https://doi.org/10.1353/wp.1995.0004.

> alized forms of mediation or subordinates them to more direct linkages between the leader and the masses; 4- an amorphous or eclectic ideology, characterized by a discourse that exalts subaltern sectors or is anti-elitist and/or anti-establishment; 5- an economic project that utilizes widespread redistributive or clientelistic methods to create a material foundation for popular sector support.[29]

Weyland argues that even though these components of populism are derived from the studies of "classic" populism, they can with some modifications be applied to Latin America in the 1990s and to non-Latin American contexts. Given the post 1990s change of organized labor in the Latin American context, he argues that neoliberalism and populist politics became compatible as a consequence of the weakening of organized labor and political parties. This resulted in the possibility of mobilizing the masses through a personalist leader, as well as the possibility for politicians to provide targeted economic benefits to specific groups simultaneous with neoliberal adjustments.[30]

The populism literature is not limited to the studies on Latin America, there is an extensive literature that focuses on the European populist parties and leaders. The European examples also converge on the creation of a duality, an enemy against which the party leaders position themselves. The elite and people divide manifest itself through issues such as xenophobia, anti-immigration and euroskepticism.[31] In short, like in Latin American context there is

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29 Kenneth M. Roberts, "Neoliberalism and Transformation of Populism in Latin America: The Peruvian Case," *World Politics* 48, no.1 (1995): 88, https://doi.org/10.1353/wp.1995.0004.

30 Ibid, 91.

31 Paul Taggart, *The New Populism and the New Politics: New Protest Parties in Sweden in a Comparative Perspective* (London: McMillan, 1996); Matthijs Rooduijn, Sarah L de Lange, and Wouter van der Brug, "A populist Zeitgeist? Programmatic contagion by populist parties in Western Europe," *Party Politics* 20, no. 4 (April 20, 2012): 563-575; Cas Mudde, "Populist Zeitgeist," *Government and Opposition* 39, no.4 (Autumn, 2004): 541-563, https://doi.org/10.1111/j.1477-7053.2004.00135.x; Umut Korkut, *Liberalization Challenges in Hungary: Elitism, Progressivism and Populism* (New York: Palgrave McMillan, 2012); Nicole VT Lugosi, "Radical Right Framing of Social Policy in Hungary: Between Nationalism and Populism," *Journal of International and Comparative Social Policy* 34, no.3 (2018): 210-233; Lorenzo Mosca, Filippo Tronconi, "Beyond Left and right: The Eclectic Populism of the Five Star

a narrative that points to a people- elite divide, the difference is the issues through which the polarizing takes place or in other words how the people and elite are defined. Mudde and Kaltwasser state that "both concepts should be conceived as empty vessels, filled in different ways by different actors."[32]

The populism in Europe is mostly exercised by right-wing political parties. The major difference of the European populism from that of the Latin American underscored by Mudde and Kaltwasser is that the first one has exclusive character while the latter has inclusive. They discuss this inclusive and exclusive characters through material, political and symbolic dimensions.[33] The excluded part of the European context in these three dimensions are the non-natives of the countries, namely the migrants. The populist political parties focus mainly on the protecting the welfare conditions of the people which they define as the natives of the countries. The structure of the population and labor market in Europe changed and became more heterogeneous paving the way for a protectionist populism, within this context the protected "people" are

Movement," *West European Politics* 42, no.6 (2019): 1258-1283; Sarah Engler, Bartek Pytlas, Kevin Deegan-Krause, "Assessing the Diversity of Anti-Establishment and Populist Politics in Central and Eastern Europe," *West European Politics* 42, no.6 (2019): 1310-1336; Erzsébet Barat, "Populist Discourses in the Hungarian Public Sphere: From Right to Left (and Beyond)," *Journal of Language and Politics* 16, no. 4 (2017): 535-550); Jens Rydgren, "Radical Right-wing Parties in Europe: What's Populism got to do with It?" *Journal of Language and Politics* 16, no. 4 (2017): 485-496; Ruth Wodak, Majid Khorasvinik, Brigitte Mral eds., *Right Wing Populism in Europe: Politics and Discourse* (London: Bloomsbury, 2013); Hans- Georg Betz, *Radical Right-Wing Populism in Western Europe* (London: The MacMillan Press, 1994); Tjitske Akkerman, Sarah L. de Lange, Matthijs Rooduijn, eds., *Radical Right-Wing Populist Parties in Western Europe: Into the Mainstream?* (London: Routledge, 2016); Cas Mudde, "Three Decades of Populist Radical Right Parties in Western Europe: So What?" *European Journal of Political Research* 52, no.1 (July, 2012): 1-19; Paul Taggart, "Populism and Representative Politics in Contemporary Europe," *Journal of Political Ideologies* 9, no.3 (2004): 269-288.

32 Cas Mudde, Cristobal Rovira Kaltwasser, "Exlusionary vs.Inclusionary Populism: Comparing Contemporary Europe and Latin America," Government and Opposition 48, no.2 (December 2012): 151.

33 Ibid, 158.

defined as the natives of the countries, and the populist parties claimed to protect their jobs, welfare benefits, cultural identity and way of life.[34] Brubaker states that

> Large scale immigration, economic transformations, and new waves of emancipatory liberalism can all be seen as projects of socially, economically, and culturally liberal elites. They therefore all create opportunities for populism in a double sense: opportunities for speaking in the name of the 'people' against elites, and opportunities for claims to protect the 'people' against threats from outside and from margins.[35]

Thus one of the defining features of the political programs of the populist parties in Europe is "welfare chauvinism" where the welfare state is for the natives while the immigrants, and other non-natives are excluded.[36] The studies that focus on the welfare politics of populist right-wing parties in Europe underscore that their policy making processes are highly influenced by the sensitivities of their constituencies.[37]

The anti-elitism in this context is voiced towards the ones who are seen as the repsonsibles of Europeanization, globalization and the ones who are regarded to be the ones who eased the entry of foreigners to the natives' lands.[38] As the non-natives emerge as a group that shrink the rights of the "people" in populist narratives, some like Brubaker approach this opposition as a distinct

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34 Rogers Brubaker, "Why Populism?" *Theory and Society* 46, no.5 (2017): 371.

35 Ibid, 372-373.

36 Cas Mudde, Cristobal Rovira Kaltwasser, "Exlusionary vs.Inclusionary Populism: Comparing Contemporary Europe and Latin America," *Government and Opposition* 48, no.2 (December 2012): 160.

37 See for a more detailed discussion on the welfare politics of the populist right wing parties in Europe: Alexandre Afonso, Yannis Papadopoulos, "How the Populist Radical Right Transformed Swiss Welfare Politics:From Compromise to Polarization," *Swiss Political Science Review* 21, no.4 (2015): 617-635; Alexandre Afonso, "Choosing Whom to Betray: Populist Right-Wing Parties, Welfare State Reforms and the Trade-off between Office and Votes," *European Political Science Review* 7, no.2 (2015): 271-292.

38 Anton Pelinka, "Right Wing Populism: Concept and Typology," In *Right Wing Populism in Europe: Politics and Discourse,* ed. Ruth Wodak, Majid Khosravinik, Brigitte Mral (London: Bloomsbury, 2013), 8.

one from that of "elites versus the people," and conceptualize it as a horizontal opposition, (while in vertical opposition is defined being between the people and the elite) the horizontal opposition is defined where the people are defined to be a homogenous block who are threatened by outside groups.[39]

This present study uses the ideational approach of populism, the thin-centered-ideology of Mudde as a point of departure to frame the political discourses of the AKP on health policy reform. The neoliberal populism literature that emerged to understand the support and consent of the lower-class to the neoliberal policies of political parties outlines common features of the populist policy making that are enlisted above and many of which can be found in the "New Turkey" narrative of the AKP in general and in the discourses on the health policy reform in particular. The neoliberal populism literature provides the explanation of this support through demonstrating the dominance of the polarizing narratives of the populist parties and leaders in contexts ranging from Europe to Latin America. Those narratives rely on the portrayal of the elites and the people as two homogenous opposing groups. The populist movements within the discourses they generate position themselves as the savior of the people and as determined actors to abolish the deeply seated establishments of their contexts which are leaded by the elites. As the chapters devoted to the discourses of the AKP show in detail the pitting of the people and doctors as the opposite sides of the health care sector is the defining feature of the narrative of the "New Turkey" mapped onto the health policy. Therefore, the anti-elite – people divide and the anti-establishment components highlighted within the populism literature will frame this study in its attempt at explaining the embracement of the health reform despite its neoliberal consequences.

1.1.2 *AKP and Populism*

The AKP was founded in 2001 by Recep Tayyip Erdoğan, Abdullah Gül and Abdüllatif Şener who were classified as revisionists of the party now called the Felicity Party which was itself the continuation of the National Outlook (*Milli Görüş)* political tradition. The Felicity Party was initially called the Welfare

39 Rogers Brubaker, "Why Populism?" *Theory and Society* 46, no.5 (2017): 362

Party and then the Virtue Party, and was differed from the National Outlook in certain respects. First, it appealed to a broader segment of the population, and secondly, it had a cross-class character while its predecessor appealed to small traders and artisans in lesser-developed parts of Anatolia. In the 1990s the Welfare Party appealed to small merchants and artisans in small Anatolian towns as well as to migrant urban slum-dwellers, Islamist professionals, intellectuals, and a rising Islamist bourgeoisie.[40]

The focus of scholarly work on the AKP changed from the time of its establishment to present. Initially studies focused on its emergence and dynamics, the background of its founders, and the economic, political, and financial context in which the party was founded. These works conceptualized the party as conservative liberal, neo-conservative, and moderate Islamic and focused on the economic context of the decade preceding the 2002 parliamentary elections.[41]

Scholarly work on the AKP following the 2007 and especially the 2011 parliamentary elections focused on their continued electoral success through three parliamentary and two local elections. The conceptual tools used to explain this success were populism and neo-populism – at times interchangeably – which were used to discuss how neoliberal policies and the structure of the majority of the AKP's electoral constituency coexisted. Thus studies devoted to interpret the electoral success of the AKP differ from those that discuss its emergence; the latter mainly discuss how the party differentiated itself from

40 Ergun Özbudun and William Hale, *Islamism, democracy and liberalism in Turkey: the case of the AKP* (New York:Routledge, 2010), 13.

41 Marcie J. Patton, "The Economic Policies of Turkey's AKP Government: Rabbits from a Hat?," *Middle East Journal* 60, no.3 (Summer 2006): 513-536, https://www.jstor.org/stable/4330284; Simten Coşar and Aylin Özman, "Center Right Politics in Turkey after the November 2002 General Election: Neo-liberalism with a muslim face," *Contemporary Politics* 10, no.1 (2004): 57-74, https://doi.org/10.1080/13569770410001701233 ; Ziya Öniş and Fuat Keyman, "Turkey at the Polls: A new Path Emerges," *Journal of Democracy* 14, no.2 (2003): 95-107, doi:10.1353/jod.2003.0042; Ziya Öniş, "Political Economy of Islam and Democracy in Turkey," in *Democracy and Development,* ed. D. Jung (New York: Palgrave McMillan, 2006), 103-128; Ergun Özbudun and William Hale, *Islamism, Democracy and Liberalism in Turkey: the Case of the AKP* (New York:Routledge, 2010).

the political parties of which its members had been part, the political and economic context of the country prior to its foundation, and the immediate agendas they proposed in their first electoral campaign.

In their study which compared the rise to power of Erdoğan and Kirschner, Öniş and Aytaç emphasize that in both Argentina and Turkey the rise of populism followed economic recessions. They underscore that both Erdoğan's and Kirschner's governments carry the core elements of populism designated by Robert Barr,[42] such as employing rhetorical appeals against the power elite, which is named as anti-establishment politics; to be an outsider to the political establishment in order to be accepted as the people's voice against the power-elite, and lastly the plebiscitary linkages between the people and the politicians, in other words the people not having control over the political processes other than voting.[43] Fujimoro's rise to power in Peru is given as an example of this type of organization by Roberts. This last type of populism as a political practice, strategy or tool is discussed in a literature initiated by Kurt Weyland that explains the compatibility of neoliberal policies and populism. Weyland states that "both contemporary populism and liberalism see individuals not groups, as the building blocks of economy and politics and advocate unmediated relationship between individuals and the state."[44]

Öniş and Aytaç argue that while the Erdoğan's succession to power shares core elements with Kirschner's in Argentina, the two differ in terms of the paths of populism they follow. While in Argentina Kirschner follows a left-

42 Robert Barr, "Populists, Outsiders and Anti-Establishment Politics," *Party Politics* 15, no. 1 (2009): 29-48.

43 S. Erdem Aytaç and Ziya Öniş, "Varieties of Populism in a Changing Global Context: The Divergent Paths of Erdogan and Kirchnerismo," *Comparative Politics* 47, no. 1 (October 2014): 42-43, https://www.jstor.org/stable/43664342.

44 Kurt Weyland, "Neoliberal Populism in Latin America and Eastern Europe," *Comparative Politics* 31, no. 4 (1999): 381-382, https://www.jstor.org/stable/422236.

wing populism, Erdoğan's is defined as right-wing populism. Instead of prioritizing redistribution policies, his priority is economic stability and physical security.[45]

Öniş states in another work that the trans-class electorate of AKP consisted of both winners and losers in neoliberalism. Thus, the party appealed to both a part of the electorate that would benefit from reforms leading to more liberal policies and a part that was excluded from the social security system.[46]

The core characteristics enlisted by Barr[47] of an anti-elite narrative, being an outsider vis-à-vis the establishment, and having a plebiscitary relationship with the people are crucial for evaluating the ways in which the Health Transformation Program was presented and framed by the AKP. Thus, while populist governments follow different paths in different contexts as Öniş and Aytaç show,[48] it can be argued that converging elements shape the way these different paths are legitimized.

In the Turkish case, strong anti-establishment narrative and outsider narratives are present in AKP language. Yüksel Taşkın, in his analysis of the AKP, emphasizes that the form of populism appropriated by the AKP is an "ambiguous mixture of material and non-material aspirations of the people that contains potential tensions among the ruling elite, counter-elite, and masses. Conservative populism in Turkey is based on a divide between 'the silent Muslim

45 S. Erdem Aytaç and Ziya Öniş, "Varieties of Populism in a Changing Global Context: The Divergent Paths of Erdogan and Kirchnerismo," *Comparative Politics* 47, no. 1 (October 2014): 45, https://www.jstor.org/stable/43664342.

46 Ziya Öniş, "Adalet ve Kalkınma Partisi'nin Ekonomi Politiği," in *AK Parti. Toplumsal Değişimin Yeni Aktörü*, ed. Hakan Yavuz (Istanbul: Kitap Yayınevi, 2010), 259.

47 Robert Barr, "Populists, Outsiders and Anti-Establishment Politics," *Party Politics* 15, no. 1 (2009): 29-48.

48 S. Erdem Aytaç and Ziya Öniş, "Varieties of Populism in a Changing Global Context: The Divergent Paths of Erdogan and Kirchnerismo," *Comparative Politics* 47, no. 1 (October 2014): 41-59, https://www.jstor.org/stable/43664342.

majority' and a 'disproportionally active and influential Westernist minority.'"[49] Taşkın states that their main emphasis is to re-appropriate the political and cultural positions held by the elite and return them to the people - the genuine sons of the nation who had been excluded.[50]

Votes for the AKP increased over consecutive three parliamentary elections that took place in 2002, 2007, and 2011 in which they won a 34, 47, and 51 percent share of the vote, respectively. This was a first in Turkish political history, and especially the results of the 2011 elections, which followed an economic crisis in 2008, led to academic studies that analyzed the electoral success of the AKP. The party favored neoliberal policies and the majority of its constituency was from the lower classes, facts that were analyzed within the framework of populism and more specifically neoliberal populism.

For instance, Umut Bozkurt differentiates the populism of the 1980s from that of the 1960-1980 period, emphasizing that it started to be located in the sphere of social reproduction instead of the sphere of production relations, and she evaluates the AKP era from this perspective.

> This process was further enhanced in the 2000s, with policies that aimed to improve the "global competitiveness of the Turkish economy" through productive capital accumulation. The AKP government resorted to more neoliberal populism in this period. Through using populist distribution techniques, it aimed to alleviate the difficult conditions for labor.[51]

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49 Yüksel Taşkın, "AKP's Move to "Conquer" the Center-Right: Its Prospects and Possible Impacts on the Democratization Process," *Turkish Politics* 9, no. 1 (2008): 55, https://doi.org/10.1080/14683840701814000.

50 Yüksel Taşkın, "AKP's Move to "Conquer" the Center-Right: Its Prospects and Possible Impacts on the Democratization Process," *Turkish Politics* 9, no. 1 (2008): 55, https://doi.org/10.1080/14683840701814000.

51 Umut Bozkurt, "Neoliberalism with a Human Face: Making Sense of the Justice and Development Party's Neoliberal Populism in Turkey," *Science and Society* 77, no. 3 (July 2013): 380, https://doi.org/10.1521/siso.2013.77.3.372. For a similar discussion on the merging of neoliberal policies and neopopulism of AKP governments see, Barış Alp Özden, "Refah Rejiminin ve

This is discussed in terms of both the policies adopted by the AKP and the discursive path it followed. For instance, in her study analyzing the role of religion in the transformation of national identity through the politics embraced by the AKP , Büke Koyuncu defines

> the populist discourse/narrative of the AKP as a way of rewriting history as the struggle of the "people" -or in other words the "real owners of the nation"- and enemies who do not want the people to develop and who look down on them. This discourse, which defines the AKP as the representative of the first group and as the only power standing against the second, legitimates the policies of the AKP in various areas and creates a protective shield vis-à-vis the opposition.[52]

It should also be noted that some scholars suggest that this discourse of siding with the victim is not only present in populist discourse but is an ever- present theme in the tradition of Turko-Islamic thought. However, the difference between the AKP and its predecessors is to put this discourse forward in a successful way.[53]

The contradiction between the neoliberal policies embraced by AKP governments and the structure of the majority of the constituency is analyzed using the framework of neoliberal populism that emerged in studies focused on Latin America. This framework explains how this contradiction can persist. Yıldırım analyzes the policies of the AKP as examples of neoliberal populism and explains the continuation of the contradiction with the party's persistent populist discourse.

> As explained by Boito by taking class character into account, neoliberal populism works as a belt that ties the impoverished masses to the

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Siyasetinin Dönüşümü," in '*Yeni Türkiye"ye Varan Yol: Neoliberal Hegemonya'nın İnşaası*, eds., İsmet Akça, Ahmet Bekmen and Barış Alp Özden (İstanbul: İletişim Yayınları, 2013), 219-241.

52 Büke Koyuncu, *'Benim Milletim…' AK Parti İktidarı, Din ve Ulusal Kimlik* (İstanbul: İletişim Yayınları, 2014), 175. (See appendix C.4 for the original.)

53 Zafer Yılmaz, "The AKP and the spirit of the 'new' Turkey: imagined victim, reactionary mood, and resentful sovereign," *Turkish Studies* 18, no. 3 (2017): 483, https://doi.org/10.1080/14683849.2017.1314763.

> hegemony project of the richest as a consequence of neoliberalism. From this perspective, the contradiction within the concept of neoliberal populism - that neoliberalism and populism exist side by side - completes the broader contradiction of the poorest becoming inactivated within the hegemony project of the richest or becoming the supporting class.[54]

Looking at the health policies of the AKP provides a lucid way to see how neoliberal populism materialized. As emphasized by Yıldırım, who sees health services as the area where pro-capital populist policies are most visible, "neoliberal populism emerges on one hand as 'health services,' which is the most appreciated policy of the AKP in the eyes of the poor population, and on the other as the transfer of sums to private health institutions and pharmaceutical monopolies, which results in the extreme increase of health expenditures."[55]

Others like Meryem Koray argue that social policies are becoming a tool of power that targets victimization at the bottom and that are applied through clientelistic populistic discourses and practices.[56]

Through analyzing electoral bulletins and party programs, she concludes that even though, discursively, social state emphasis occupies a major space (as there has not been a discourse based on "rights"), the frequent usage of the term "protector of the orphans" allows the social policy of the AKP to be defined as "bottom victimizations policy."[57]

1.1.3 *How the Study Engages with the Literature on Populism?*

This study takes the "thin-ideology" definition of populism by Mudde as a departure point and makes use of the concepts of neoliberal populism and neopopulism that emerged in the literature on Latin America as conceptual tools

54 Deniz Yıldırım, "AKP ve Neoliberal Popülizm" in *AKP Kitabı: Bir Dönüşümün Bilançosu,* ed. İlhan Uzgel, Bülent Duru (Ankara: Phoenix, 2009), 81. (See appendix C.5 for the original.)

55 Ibid, 81.

56 Meryem Koray, "AKP Dönemi: Neo-Liberalizm, Neo-Muhafazakarlık, Neo-Popülizm Beşiğinde Sallanan Sosyal Devlet ve Sosyal Politika," in *Himmet Fıtrat Piyasa: AKP Döneminde Sosyal Politika*, ed. Meryem Koray and Aziz Çelik (İstanbul: İletişim Yayınları, 2015), 43.

57 Ibid, 48.

to pursue its discussion of the Turkish Health Reform debate. While different approaches enlist diverse building blocks that characterize populism (which undoubtedly overlap), I will make use of a combination of those components to discuss the health policy discourses of the AKP through the conceptual framework of neoliberal populism.

Those components are an anti-establishment emphasis in terms of criticism of the institutions, bureaucracy, and political parties; an anti-elite emphasis that defines the people as the rulers against the elites; and one–man rule that emerges as a means of mobilization -a negation of intermediary political institutions between the people and the leader and the leader's identification with the people through his emphasis on being one of them.

The anti-establishment emphasis dominated the discourses of the AKP governments especially throughout the theme of "New Turkey." The state institutions before the AKP's arrival to power were portrayed as not serving the people but as maintaining the privileges of a certain segment of society, mostly portrayed as Republican People's Party (Cumhuriyet Halk Partisi or CHP) and its electorate. Within the "elite versus the people" discourses of the AKP, bureaucracy and state institutions emerged as places where the inequality among these two groups materialized. For instance, serving the people emerged as a counter position with regard to the institutional habits of the 'old Turkey' and was presented as a defining feature of the 'New Turkey' of the AKP.

The anti-establishment discourse was formed via how health services improved and were extended to cover previously excluded people. The divide between the people and the elite, was most specifically mapped onto the doctor-patient divide which the pro-reform discourse constructed. The regulations regarding the detainment of patients, the introduction of a general health insurance scheme, and improvements to the infrastructure of health care units in eastern provinces were other issues through which anti-establishment discourse emerged in the narratives of the AKP. Through these issues, the AKP underscored their difference through their prioritization of the endowment of equality and serving the people.

The anti-elite component emerged as a theme that materializes through the patient-doctor divide in the discourses of the AKP. In the anti-elite discourse, the main emphasis is the sharp division between two groups - the elites and the people- which emerges as the doctors versus the people. The main difference of this theme in the case of this research from that of the anti-establishment theme is the strong emphasis on two groups of people and the clear-cut definition of doctors as elites. In this sharp divide the portrayal of the doctors includes the elements of "elites" that are underscored in the populism literature, the most prominent of which is - corruption and impurity compared to the people. In the Turkish case, this corruptness and moral impurity manifests itself – in the field of health - through issues such as obligatory rotation, the anti-HTP position of the TTB, the full-time employment law, and the alleged demand of doctors for extra payments.

Thirdly, the one-man, strong leader component, wherein the leader identifies himself with the people, emerges strongly in the health reform discourses, especially during electoral campaigns. This component of populism, as mentioned earlier, involves the formation of a direct relationship between the leader and the people without intermediary political institutions. In the case of health policy reforms, during the presentation of the general health insurance law and the regulations regarding the common usage of hospitals by people under different social security schemes – preceding the passage of the general health insurance law - Recep Tayyip Erdoğan underlined boldly how as a former worker, he himself experienced the malfunctioning of the SSK system and hospitals. Thus, he asserted that he understood the difficulties experienced by the people, and as a consequence, he prioritized ensuring equality among the people and serving the up until-then neglected masses. The issue of general health insurance and the provision of health services to SSK-covered citizens in hospitals not previously available to them was presented and emphasized by frequently mentioning the leader of the main opposition party, Kemal Kılıçdaroğlu. As Kılıçdaroğlu was a former president of the SSK, the discourses of Erdoğan on the general health insurance system identified himself with the people and Kılıçdaroğlu with the "old Turkey" in which a malfunctioning social security system caused deep-seated inequalities.

1.1.4 *Theoretical Literature on Turkish Health Care Reform*

The general transformation of the welfare regime in post-1980s Turkey and the transformation of the Turkish health care system in particular, became the subject of scholarly studies from various perspectives in the last decade. Each sheds light on different aspects of the impact of changes that came about in the 2000s in the domain of health care under AKP governance.

The sophisticated literature on health reform in Turkey emphasized the dual trend that characterized reform in health. As studies on the topic demonstrate, on the hand, there was a universalist trend that aimed both to abolish the inegalitarian structure of the health system and to extend coverage. On the other hand, there was a move to introduce marketization and alter the role of the state in the health system.

As will be discussed in detail in Chapter 2, Keyder[58] has drawn attention to global as well as domestic populist dynamics behind health care reform in Turkey. He has suggested that extending health care - the reform did through the introduction of a General Health Insurance scheme- to segments of the population excluded from health care had the clear potential to appeal to the electorate base of the AKP, among whom those without health care constituted a significant constituency. Yet, both Keyder and others have underscored that the reasons for Turkish health care reform cannot be confined to domestic politics but must be understood in relation to the global context of health care reform[59] discussed in the Chapter 2. The existence of global and domestic dynamics also accounts for the dual nature of health care reform.

This emphasis on dualism emerges in studies and discussions regarding the introduction of health policy reforms as a process of marketizing and universalizing at the same time.[60] Dualism is also emphasized in a different way

58 Çağlar Keyder, Giriş (Introduction) to *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, ed. Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007), 22.

59 Ibid, 22.

60 Tuba Ağartan, "Marketization and Universalism: Crafting the Right Balance in the Turkish Health System," *Current Sociology* 60, no. 4 (2012): 456-471, https://doi.org/10.1177/0011392112438331.

in studies that argue that health reform created new inequalities even while abolishing the inequalities of the pre-reform system.[61]

Some other studies conceptualize the policy-making of AKP in the field of health as having a dual agenda: neoliberalizing on one hand and making compromises to those policies to the ends of maintaining the support of the constituency.[62] Others argue that the consequences of this transformation are experienced differently by diverse groups, hence creating a dual response.[63]

The dualism in these discussions emphasizes the distinctiveness of the Turkish experience with regards to global health reform trends by pointing to the oscillation of Turkish health policy-making between two coexisting tendencies.

The emphasis on two coexisting tendencies emerges not only in studies on health care reform but also in analyses that highlight the broader dynamics of welfare reform in Turkey. The characterization of the Turkish welfare regime in the AKP period by Buğra and Keyder builds on the argument that the process of change of the up-until-then fragmented structure of Turkish social policy environment differs from the experience of other countries as a consequence of the dynamics at play in the country's political environment.[64] While on one hand the background of the change is similar to that other welfare states - such as the fiscal constraints, a new balance between the state and the market, and the decreasing level of basic, universal coverage by the state- the distinction comes from the opposing dynamics at play. On one hand there is a conservative liberal tendency of downsizing the state through fiscal controls

61 Volkan Yılmaz, "Changing Inequalities in Access to Health care Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey* 48 (March 2013): 55-77, https://doi.org/10.1017/S0896634600001886.

62 Tim Dorlach, "AKP between Populism and Neoliberalism: Lessons from Pharmaceutical Policy," *New Perspectives on Turkey* 56 (November 2016): 55-83, https://doi.org/10.1017/npt.2016.23.

63 Ayşe Buğra and Ayşen Candaş "Change and Continuity under an Eclectic Social Security Regime: The Case of Turkey," *Middle Eastern Studies* 47, no. 3 (May 2011): 515-528, https://doi.org/10.1080/00263206.2011.565145.

64 Ayşe Buğra and Çağlar Keyder, "The Turkish Welfare Regime in Transformation," *Journal of European Social Policy* 16, no. 3 (2006): 211-228, https://doi.org/10.1177/0958928706065593.

that is complemented by Islamic notions of charity, and on the other, there is the tendency towards universalism.[65]

A similar line of argument is presented by Eder which emphasizes how welfare policies are shaped by clientelistic tendencies that were not necessarily a characteristic feature of the AKP but were systematically employed and expanded by the AKP.[66] Eder highlights the duality observed in AKP reforms: On one hand, the neoliberal tendencies of AKP governments and the state were manifested in increasingly privatized health care and private health insurance that signified the retreat of the state from the provision of social services. On the other, the presence of the state control increased via the General Directorate of Social Assistance and Solidarity (*Sosyal Yardımlaşma ve Dayanışma Genel Müdürlüğü* or SYDGM).[67] As Eder underscores, the SYDGM is accountable only to the prime ministry and manages Social Aid and Solidarity Foundations (*Sosyal Yardımlaşma ve Dayanışma Vakfı* or SYDV) that in turn manages the funds autonomously. The majority of the resources were for predesignated purposes.[68] The inclusion of the private and third sectors in welfare provision through the SYDGM paves the way for political arbitrage, clientelism, and the arbitrary involvement of the state in welfare provision.[69]

Dorlach[70] on the other hand, focuses on the duality of the policy making mechanism of the AKP. By examining the pharmaceutical price and expenditure policy of the AKP government after 2009, which resulted in a 20 billion lire savings in Turkish pharmaceutical expenditures, Dorlach argues that despite being known for business-friendly and neoliberal leaning regulations,

65 Ibid, 226-227.

66 Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey," *Middle East Law and Governance* 2, no. 2 (January 2010): 182, https://doi.org/10.1163/187633710X500739.

67 Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey," *Middle East Law and Governance* 2, no.2 (January 2010): 182, https://doi.org/10.1163/187633710X500739.

68 Ibid, 174.

69 Ibid, 182.

70 Tim Dorlach, "AKP between Populism and Neoliberalism: Lessons from Pharmaceutical Policy," *New Perspectives on Turkey* 56 (November 2016): 55-83, https://doi.org/10.1017/npt.2016.23.

the global budget introduced in the pharmaceutical policy was not in the interests of the pharmaceutical industry. The savings were made through cuts to the profit of pharmaceutical producers and distributors, not through privatizing the cost of medicines.

This choice demonstrates the sensitivity of the AKP with respect to the access of the lower classes to the medicines given that they make up a significant part of its constituency. Thus, he concludes that the AKP's social and economic policies are shaped by the interests of the majority in its constituency but, at the same time, that there is no monolithic policy making structure within the party. On one side are technocrats that are inclined towards neoliberal policies, and on the other side is the party leader who prioritizes electoral success.[71] Dorlach's take on the duality of health policy formulation focuses on the policy making process of the AKP and the dual agenda behind the introduction of its health policy changes.

Ağartan's discussion of health policy transformation focuses on the two contradictory tendencies at play in policy making, in terms of both the making of policy changes and their consequences. Her research[72] situates the Health Transformation Program in the context of the changing welfare regime of Turkey. Emphasizing that these health reforms cannot be understood by looking only at the policy recommendations of international actors, Ağartan's research demonstrates how various policy actors played parts in the HTP. Ağartan states that the HTP has inherent contradictions as it introduced universalist and market elements simultaneously.[73] The duality of the nature of the Health Transformation program is verbalized as a contradiction in her discussion. She emphasizes that while on one hand the HTP introduced universal access to health care services, on the other, marketization also took place.

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71 Tim Dorlach, "AKP between Populism and Neoliberalism: Lessons from Pharmaceutical Policy," *New Perspectives on Turkey* 56 (November 2016): 55-83, https://doi.org/10.1017/npt.2016.23.

72 Tuğba Ağartan, "Turkish Health System in Transition: Historical Background and Reform Experience" (PhD Diss., State University of New York, 2008).

73 Tuba Ağartan, "Marketization and Universalism: Crafting the Right Balance in the Turkish Health System," *Current Sociology* 60, no. 4 (2012): 456-471, https://doi.org/10.1177/0011392112438331.

Günal evaluates the Turkish health care system in the republican period focusing on the socialization of health care services in 1961.[74] The research, though it focuses on the socialization of Turkish health care system in the republican period, sheds light on health care reform processes that took place in the 2000s. She concludes that the issues addressed by the reforms introduced in the Health Transformation Program in 2003 did not differ from those in the post 1980s period; the difference was the AKP's determination to realize them. Inequality and inefficiency in the Turkish health care sector have been subjects of discussion since the 1960s, but the solutions offered by the AKP differ from those proposed in previous decades, except in having a General Health Insurance model. Proposed reforms took the form of decentralization, autonomization of hospitals towards privatization, general practitioner model, and the promotion of the private sector. The major difference of the AKP, according to Günal, is the introduction of purchasing services from the private sector. Even though health is not directly commodified, she concludes that these polices had negative consequences in terms of equality and efficiency.

Bengi Demirci's comparative approach to the HTP from a public administration perspective looks at how and to what extent the health reform processes of the British NHS and Turkish health care system differ from and resemble each other. Her research conducted in a public hospital reaches the conclusion that health reforms in general and the HTP in particular brought about financial and organizational changes that had significant consequences for the economic, political, social, clinical, managerial, equity, and conceptual aspects of health care systems.[75]

As for these consequences, Yılmaz's discussion points to how the aims of the Health Transformation Program are prone to create consequences that are

74 Asena Günal, "Health and Citizenship in Republican Turkey: An Analysis of the Socialization of Health Services in Republican Historical Context" (PhD Diss., Boğaziçi University, 2008).

75 Bengi Demirci, "Transformation in the Organizational and Financial Set up of the Healthcare System in Turkey – Its Repercussions and Similarities with the British Model" (PhD Diss., Middle East Technical University, 2012)

not verbalized. The dualism mentioned earlier emerges in some scholarly discussions as consequences of health care policy changes within the framework of the Health Transformation Program. Yılmaz,[76] for instance, argues that the AKP stepped in with Health Transformation Program to abolish occupational-based inequalities through the unification of public health insurance schemes and equalization of the benefits for all publicly-insured patients. But as a consequence of the continuation of the social-insurance based health care financial structure and means-tested exemption from the payment of premiums along with the introduction of contributory payments for prescribed medicines and medical visits, the new health-care system has inherent income-based inequalities. Thus, with the HTP, a shift in inequalities took place rather than a complete eradication of them. His take on the issue is an example of how the transformation of a fragmented system creates another kind of inequality based not on employment status but on income. He states that:

> The AKP's HTP promised to eliminate all the occupational status based inequalities (especially the privileged status of the civil servants) and provide equal access to health services for low income citizens. However the promise of equal access remained unfulfilled.[77]

1.1.5 *The Contribution of the Dissertation*

This dissertation contributes to these analyses of the political dimension of health care reform in Turkey. This dissertation contributes the debate on the success of populism and shows health care is the primary component of the populist party politics – an issue that enabled the AKP to fullfil its populist discourse – to convince the populist audience. This study approached popu-

76 Volkan Yılmaz, "Changing Inequalities in Access to Health care Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey* 48 (March 2013): 55-77, https://doi.org/10.1017/S0896634600001886.; Volkan Yılmaz, *Politics of Healthcare Reform in Turkey* (London:Palgrave Mc Millan, 2017).

77 Volkan Yılmaz, "Changing Inequalities in Access to Health care Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey* 48 (March 2013): 73, https://doi.org/10.1017/S0896634600001886.

lism not as a discourse only but showed how it worked in practice. The political dimension of health reform is also been mentioned in the literature. Eder, for example, argues that welfare regime transformation, which includes the reform to health, extended the state's power and created enormous room for political arbitrage and clientelism. According to her, this politicization "can also explain why there has not been any significant political opposition to the welfare reforms in the country."[78] She also draws attention to "the political context within which the welfare reforms occur in the developing countries" where "there are fewer organized constituencies and/or economic groups engaging in these debates."[79] She writes "In the specific context of Turkey, the high popularity of some of the reforms coupled with the absence of a successful past dealing with welfare provision on the part of the opposition parties, have undermined prospects for political debate"[80]

Buğra and Candaş also reflect on the political dynamic of welfare reform. They suggest that reform pitted a formally-employed minority whose rights were being eroded through ongoing neoliberal policies against an excluded group that the reform, continues to support through assistance in kind, charity and clientelism.[81]

This dissertation contributes to these analyses of the political dimension of welfare reforms by demonstrating how the AKP's discourse on health reform depended on pitting two groups - health providers and receivers - against each other. It does so by tracing how the two reform trends identified in the literature on Turkish health reform - universalism and marketization -were taken up and foregrounded by various, contending actors and used in the political discourse and debates on health reform.

78 Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey," *Middle East Law and Governance* 2, no. 2 (January 2010): 182, https://doi.org/10.1163/187633710X500739.

79 Ibid, 182.

80 Ibid, 182.

81 Ayşe Buğra and Ayşen Candaş "Change and Continuity under an Eclectic Social Security Regime: The Case of Turkey," *Middle Eastern Studies* 47, no.3 (May 2011): 526, https://doi.org/10.1080/00263206.2011.565145.

In this respect I found studying the narrative of the government on the HTP and the counter narrative(s) developed by other actors – led and shaped mainly by the TTB - are worthy of academic attention. The study of these narratives allows one to trace how changes introduced to the financing and organization of health care services in Turkey were presented to the public, how they were made "known," and how they were contested.

The major contribution of my research is the argument that structural changes that took place in the health sector in Turkey were accompanied by a coherent political discourse of a "New Turkey." This dissertation shows that despite its privatizing and commodifying consequences the health reform is widely embraced and health became an area through which the "New Turkey" was defined and portrayed by the AKP. Previous studies on health policy reform in Turkey looked at the consequences of structural changes taking place in the health sector; the present study complements these by delving into the discursive level and shedding light to how health reform became a tool that concretely translated the broader, populist "New Turkey" narrative of the AKP for its electorate.

§ 1.2 Design of the Research

As the research discusses how AKP government presented health policy reforms within a broader narrative/discourse of a New Turkey, on one hand, and how the TTB created an opposition movement/ counter discourse, on the other, the research design is based on materials that reflect the views of these actors on health policies.

With regard to the government, an extensive scanning of the media was conducted for the period from November 2002 to July 2011. The choice of newspapers was made according to their political proximity to the government during this period. Newspapers chosen were the dailies *Zaman* and *Yeni Şafak*, which were scanned for news and columns on health policy changes in particular and the Turkish health sector in general. It should be noted that the 17-25 December 2013 corruption investigations targeting the government dramatically changed the relationship between AKP circles and the Gülen movement. Following these *Zaman* can hardly be defined as a pro-government

newspaper. Starting on 4 March 2016 the newspaper was run by a trustee by the 6. Criminal Court of Peace in Istanbul.[82] Following the 15 July 2016 coup attempt, the newspaper was closed by a statutory decree issued by the government authorized by the state of emergency declared on 27 July 2016.[83]

Other materials consisted of publications of Ministry of Health, the electoral bulletins of the AKP, the programs of the 58th, 59th, 60th and 61st governments, the speeches of Recep Tayyip Erdoğan during electoral campaigns, *Türkiye Bülteni* (the monthly official publication of the AKP), and occasional publications made by the AKP regarding parliamentary speeches made on Doctor's Day (14 March) during the 2003-2011 period.

For the part of the dissertation on actors who contested the health reforms, three types of materials were used. Firstly, a scan of the media was conducted for the period from November 2002 to July 2011. The dailies *Birgün* and *Cumhuriyet* and the online news outlet *Bianet* were scanned for news articles and columns related to the Turkish health sector, health policy changes, and the Health Transformation Program, in particular.

The second set of materials consisted of TTB publications: annual reports, publications regarding specific issues in the health sector, the bi-monthly periodical of the TTB *Toplum ve Hekim*, and the publications of the Health and Social Workers' Union (SES or Sağlık ve Sosyal Hizmet Emekçileri Sendikası) and Revolutionary Health Workers' Union (Dev-Sağlık-İŞ or Devrimci Sağlık İşçileri Sendikası).

The third set of materials consisted of in-depth interviews conducted with current and previous administrative board members of the TTB, SES, and Dev Sağlık İŞ as well as with activists and journalists who write extensively on Turkish social policy, Turkish health policy ,and the Health Transformation Program, in particular.

82 "Zaman Gazetesine Kayyum Atandı," BBC Türkçe, March 4, 2016, http://www.bbc.com/turkce/haberler/2016/03/160229_zaman_gazetesi_kayyum.

83 "İşte Kapatılan 45 Gazete, 16 Televizyon, 16 Dergi, 3 Haber Ajansı ve 23 Radyonun İsmi," *Cumhuriyet*, July 27, 2016, http://www.cumhuriyet.com.tr/haber/siyaset/575381/iste_kapatilan_45_gazete__16_televizyon__16_dergi__3_haber_ajansi_ve_23_radyonun_ismi.html.

§ 1.3 Dissertation Outline

The dissertation consists of three main parts. The organization of these three parts follows the title of the dissertation. The first part, entitled "Global Health Reform: Situating Turkish Health Reform in the Global Context," consists of one chapter that presents global health reform trends. This chapter first looks at what global reform in health care is composed, highlighting common elements that characterize waves of health care reform around the world. Secondly, based on dominant classifications used in the relevant comparative health policy literature, the chapter briefly discusses different health care systems in advanced, industrialized countries and the trajectory of their reform after 1980. This second section also offers a discussion of health care reform process in some late-developing countries without mature welfare states whose reform experiences resemble that of Turkey. Finally, the chapter engages the question of where Turkish health care reform stands in this broader picture of global health care reform. In addition, this final section provides an overview of the most prominent characteristics of the reform in Turkey during the implementation of the HTP between 2003 and 2011.

The second part of the dissertation entitled "Packaging and Justifying Health Reform" is composed of three chapters and concerns the "government" side of health policy reform debates in Turkey.

Chapter 3, entitled the "AKP's Promotion of the Health Reform: The Discourse of Revolution in Health," will examine how the "revolution in health" discourse of the AKP government – which builds on the arguments of a "human centered mentality," the promise of equality not enjoyed in pre-AKP periods, and an image of a government that sides with the people – was constructed around specific issues regarding health care. The chapter will demonstrate how the government presents itself as determined to end deficiencies and victimizations in health sector that it claims were caused by the previous system. The first subsection will concern cases of the patients detained in hospitals, and the second will concern how geographic and social-security based inequalities are claimed to be overcome by the AKP government.

Chapter 4, entitled "Presenting the Novelties and the Accomplishments of an Unprecedented Reform," is on government discourse focusing on the claim that changes introduced by the AKP have no equivalent in the pre-AKP period. This discourse involves three themes. The first is the claim to make the health system more efficient by increasing the number of health personnel and the number and capacity of health care units and decreasing the bureaucratic steps and costs of accessing health-care services. The second is the claim to make the system higher quality by increasing the quality of citizens' health, increasing the quality of health care infrastructure and equipment, introducing health services not available before, introducing of new technologies to health care services. Third, is the discursive emphasis on patients' rights. As the chapter will demonstrate, statistics play a key role in the AKP's claim to success in health reform since AKP officials continuously refer to statistics (increases in health units, bed capacities, and ambulances and decreases in mortality rates) to proclaim the accomplishments of their government in healthcare.

Chapter 5, entitled "The Health Reform in Pro-Government Media Discourse: Bidding the Providers against the Receivers" is based on a scan of two pro-government newspapers between 2002-2011 and discusses five themes by which the (at the time) pro-government media portrayed health care reform in line with the broader, anti-elite discourse of the government. These themes include the portrayal of the pre-AKP health system as one that victimized the people, the portrayal of health reform as a fight against corruption, the portrayal of doctors as driven by self-interest, the dismissal of the discourses of actors opposed to the Health Transformation Program, and the celebration of the reforms and novelties of the new health system.

The third part of the dissertation, entitled "Contesting Health Reform," is composed of three chapters on actors that opposed the Health Transformation Program. Chapter 6 entitled "Who are the Contesters?" is composed of four subsections. First, the actors that make up the opposing side of the debate, namely the TTB, SES and Dev Sağlık İş, are presented. The chronology of strikes organized by the TTB and the opposition to laws regarding policy changes in the health sector through legal means are summarized. In the following three subsections, which are based on in-depth interviews conducted

with members of the aforementioned associations and unions, three themes of the position of the actors that contested the Health Transformation Program are discussed: How do contesting actors delineate their position? How do they evaluate the Health Transformation Program? And how do they justify the strikes and demonstrations they organized?

Chapter 7 "Contesting the Privatization and Commodification of the Health Services" focuses on the evaluation of health care reform by opponents as a process of commoditization given specific measures that took place from 2002-2011, such as the transfer of SSK hospitals to the Ministry of Health, Public Hospital Union. Chapter 8 "Highlighting the Health Care Reform's Negative Impacts on the Health-care Receivers and Health-care Providers" discusses themes foregrounded by opponents with respect to the impact of health care reform on the working conditions of health care providers and on the rights of the health care receivers.

2

Global Health Reform: Situating Turkish Health Reform in a Global Context

Reform in health care is a global phenomenon that dates to the 1980s. Thus, the reform agendas of the health care system in individual countries can neither be considered independently from each other nor from the paradigmatic shift in the global political economy of the 1980s. This chapter firstly looks at the composition of global reform in health care, highlighting common elements that characterize waves of health care reform across the world. Secondly, based on dominant classifications used in the relevant comparative health policy literature, the chapter briefly discusses different health care systems in advanced industrialized countries and the trajectory of their reform after the 1980s. This second section also offers a discussion of the health care reform process in some late-developing countries without mature welfare states whose experiences resemble those of Turkey. Finally, the chapter engages the question of where Turkish health care reform stands in this broader picture of global health care reform. In addition, this final section provides an overview of the most prominent characteristics of the reform in Turkey during the implementation of the HTP between 2003 and 2011.

§ 2.1 The Global Reform in Health Care

Since the 1980s, reform in health care has become a global phenomenon. Health care reforms in the period following the 1980s have been initiated across a vast geography covering Europe, Latin America, and East Asia. This broad geographic span as well as common, fundamental features of health care reform in countries with diverse historical and institutional arrangements have led some to label the reform of health care as a global "epidemic"[1]

The reasons as well as the common, basic elements that characterize this global reform in health are the subject of an important social science literature.[2] Based on this literature, this section introduces the major reasons and

1 Rudolf Klein, "Health Care Reform: The Global Search for Utopia," *British Medical Journal* 307, no. 6907 (1993): 752-752.

2 Jacob S. Hacker, "Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform," *British Journal of Political Science* 34, no. 4 (2004): 693–724, DOI: 10.1017/S0007123404000250; Chris Ham, ed., *Health Care Reform: Learning from International Experience* (Buckingham and Philadelphia: Open University Press, 1997); R. B. Saltman, and J. Figueras, *European Health Care Reform: Analysis of Current Strategies*, (WHO Regional Office for Europe:Copenhagen, 1997); Mia Defever, "Health Care Reforms: the unfinished agenda," *Health Policy* 34, no. 1 (1995): 1-7, https://doi.org/10.1016/0168-8510(95)00762-H; R. Saltman, J Figueras, and C. Sakellarides, eds., *Critical Challenges for Health Care Reform in Europe* (Buckingham: Open University Press, 1998); Jong-Chan Lee, "Health Care Reform in South Korea: Success or Failure?" *American Journal of Public Health* 93, no. 1 (January 2003): 48-51, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447690/; Supasit Pannarunothai, Direk Patmasiriwat and Samrit Srithamrongsawat, "Universal health coverage in Thailand: Ideas for Reform and Policy Struggling," *Health Policy* 68, no. 1 (2004): 17-30, https://doi.org/10.1016/S0168-8510(03)00024-1; Mita Giacomini et.al, "The policy Analysis of 'Values Talk': Lessons from Canadian Health Reform," *Health Policy* 67, no.1 (2004): 15-24, https://doi.org/10.1016/S0168-8510(03)00100-3; Maria Petmesidou and Ana M. Guillén, "'Southern-style' National Health Services? Recent Reforms and Trends in Spain and Greece," *Social Policy and Adminstration* 42, no. 2 (April 2008): 106-124, https://doi.org/10.1111/j.1467-9515.2007.00598.x; Clare Bambra, "Worlds of Welfare and the Health Care Discrepancy," *Social Policy and Society* 4, no. 1 (January 2005): 31-41, https://doi.org/ 10.1017/S1474746404002143; Julio Frenk, "Dimensions of Healthcare Reform," *Health Policy* 27, no. 1 (1994): 19-34, https://doi.org/10.1016/0168-8510(94)90155-4; Viroj Tangcharoensathien, et.al, "Health Financing Reforms in Southeast Asia: Challenges in Achieving Universal Coverage," *The Lancet*

basic common components of the health care reforms that took place after the 1980s around the world.

377, no. 9768 (March 2011): 863-873, https://doi.org/10.1016/S0140-6736(10)61890-9; Alan Cribb, "Organizational Reform and Health-care Goods: Concerns about Marketization in the UK NHS," *Journal of Medicine and Philosophy* 33, no. 3 (2008): 221-240, https://doi.org/10.1093/jmp/jhn008; Patrick Hassenteufel and Bruno Palier, "Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems," *Social Policy and Adminstration* 41, no. 6 (December 2007): 574-596, https://doi.org/10.1111/j.1467-9515.2007.00573.x; Henri Bergeron and Constance Nathanson, "Construction of a Policy Arena: the Case of Public Health in France," *Journal of Health Politics, Policy and Law* 37, no. 1 (October 2011): 5-36, https://doi.org/ 10.1215/03616878-1496002; Dani Filc, "The Health Business under Neo-liberalism: the Israeli Case," *Critical Social Policy* 25, no. 2 (May 2005): 180-197, https://doi.org/10.1177/0261018305051325; Hyoung-Sun Jeong, "Health Care Reform and Change in Public-private Mix of Financing: a Korean Case," *Health Policy* 74, no. 2, (January 2005): 133-145, https://doi.org/ 10.1016/j.healthpol.2004.12.017; Donald W. Light, "From Managed Competition to Managed Cooperation: Theory and Lessons from the British Experience," *The Milbank Quarterly* 75, no. 3 (1997): 297-341, https://dx.doi.org/10.1111%2F1468-0009.00058; Wynand P. M. M. Van de Ven, "Market-oriented Health Care Reforms: Trends and Future Options," *Social Science & Medicine* 43, no. 5 (1996): 655-666, https://doi.org/10.1016/0277-9536(96)00111-6; Çağlar Keyder et. al. eds., *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar* (İstanbul: İletişim Yayınları, 2007); Tuba Ağartan, "Sağlıkta Reform Salgını" in *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds. Cağlar Keyder et. al. (İstanbul: İletişim Yayınları, 2007), Tuba Ağartan "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60 no. 4 (2012): 456-471, https://doi.org/10.1177/0011392112438331; Tim Dorlach, "AKP between Populism and Neoliberalism: Lessons from Pharmaceutical Policy," *New Perspectives on Turkey* 55 (November 2016): 55-83, https://doi.org/10.1017/npt.2016.23; Volkan Yılmaz, "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey,* Volume: 48 (March 2013): 55-77, https://doi.org/10.1017/S0896634600001886; Volkan Yılmaz, *Politics of Healthcare Reform in Turkey* (London:Palgrave Mc Millan, 2017); Tuğba Ağartan, "Turkish Health System in Transition: Historical Background and Reform Experience" (PhD Diss., State University of New York, 2008); Asena Günal, "Health and Citizenship in Republican Turkey: An Analysis of the Socialization of Health Services in Republican Historical Context" (PhD Diss., Boğaziçi University, 2008); Bengi Demirci, "Transformation in the Organizational and Financial Set-up of the Health Care System in Turkey: Its Repercussions and Similarities with the English Model" (PhD Dissertation, Middle East Technical University 2012).

Gonzales-Block summarizes the basic reasons and dynamics behind the reforms to health care as follows:

> In many countries throughout the world health financing and service institutions are being reformed to meet diverse yet conflicting pressures, on the one hand there are structural adjustments of national economies to meet fiscal crisis and national debt, leading to a shrinking role of the state. On the other there is a growing pressure on health systems due to rising health needs and costlier technology.[3]

As can be inferred, one cause behind the global reform of health care has to do with the need to meet a rising demand. This rising demand for health care itself stems from demographic changes. Increasing elderly populations require more health services. In addition, an overall increase in the demand from patients for the latest technology and medications has also contributed to this rising demand for health care.[4]

Apart from concern to meet a rising demand and - perhaps more importantly- reforms to health systems have been introduced to control ever-increasing expenditures in health care across the world. As Keyder notes, "there is a common concern in all countries. Expenditures in the health sector

3 Miguel Angel Gonzalez Block, "Comparative Research and Analysis Methods for Shared Learning from Health System Reforms", *Health Policy* 42, no. 3 (1997): 188, https://doi.org/10.1016/S0168-8510(97)00072-9.

4 Tuba Ağartan, "Sağlıkta Reform Salgını," in *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007), 50; Çağlar Keyder, Giriş (Introduction) to *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007); Richard Freeman and M. Moran, "Reforming Health Care in Europe," *West European Politics* 23, no. 2 (2000): 36, https://doi.org/10.1080/01402380008425366 ; Chris Ham, "Series Editor's Introduction" in *Health Care Reform: Learning from International Experience*, ed. Chris Ham (Buckingham and Philadelphia: Open University Press, 1997): vii ; Andrew C. Twaddle, "Health system reforms: Toward a Framework for International Comparisons," *Social Science and Medicine* 43, no.5 (1996):637-654; Miguel Angel Gonzalez Block, "Comparative Research and Analysis Methods for Shared Learning from Health System Reforms", *Health Policy* 42, no. 3 (1997): 187-209; Mia Defever, "Health Care Reforms: the Unfinished Agenda," *Health Policy* 34, no. 1 (1995): 1-7, https://doi.org/10.1016/0168-8510(95)00762-H.

are increasing at a much higher rate than income."[5] Thus, cost-containment was a fundamental aim of health care reforms in many countries that experienced an increase in health expenditures because of increasing demand from an aging population, advances in medical technology, and increasing pharmaceutical prices.

There are, however, other reasons behind global health care reform that were not confined to changing dynamics in the health sector. These concern a paradigm shift throughout the world in the 1980s towards economic liberalization. The reform in health care systems should thus also be considered in the context of this paradigm shift of the late 1970s and 1980s.

This paradigm of neoliberalization behind post-1980 social policy reforms questioned the role of the state as a provider of social services and health care, advocating instead the introduction and strengthening of market mechanisms in all realms of social welfare. International organizations such as the International Monetary Fund (IMF) and the World Bank (WB) played a leading role in translating this neoliberal orthodoxy into concrete social policies.

There was, however, a move away from the strict economic orthodoxy initially promoted by the IMF, since policies that the IMF initiated in the 1980s led to devastating social consequences for Latin America. With this shift, the WB started to employ an approach that addressed the social consequences of neoliberalization, focusing on poverty alleviation and social policies.[6]

With this new mission, The WB became a strong actor, setting the agenda of post 1980s health policy reforms around the world. It introduced or proposed health care reform packages in many countries including Turkey. These packages were viewed as part of the poverty reduction schemes of the WB as well as a response to increasing costs in the health sector.[7]

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5 Çağlar Keyder, Giriş (Introduction) to *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007), 33.

6 Ibid, 22.

7 For further discussion see Çağlar Keyder et. al. eds., *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*. (İstanbul: İletişim Yayınları, 2007).

Along with the WB, the World Health Organization (WHO) emerged as another important international actor that influenced global reform in health care.[8]

According to Lister, in the new paradigm set by the WB, the WHO played the role of making the WB seem "less aggressive, more caring" on issues of social policy.[9] A change in top-level advisors with the election of Dr. Grow Harlem Brundtland was also an indicator of change.[10] Thus, the institutional changes that took place in the WHO, an institution committed to securing the health of the people and challenging pharmaceutical corporations in the 1970s, provide insight into how the economic liberalization paradigm was reflected in global health care reform.[11]

The fact that international organizations such as the WB and the WHO influenced the content and course of health care reforms in many countries led to a situation where common elements were introduced into the health

8 WHO was established in 1948 as a specialist agency of the United Nations (UN) with the signature of 61 countries. John Lister, *Health Policy Reform: Driving the Wrong Way?* (Middlesex :Middlesex University Press, 2005), 68.

9 Ibid, 69.

10 Ibid, 72.

11 The role of the WHO is defined in Article 2 of its constitution as follows: "to act as the directing and coordinating authority on international health work."(Meri Koivusalo, "The Shaping of Global Health Policy," in *Morbid Symptoms Health under Capitalism*, eds., Leo Panitch and Colin Leys, Socialist Register, London: The Merlin Press, 2010, 279.) Alma Ata Declaration of 1978 and Health for All 2000 Project that was an initiative of UNICEF and WHO, were the result of the International Conference on Primary Health Care, that took place in Alma Ata, USSR 6-12 September 1978. In the declaration, it was stated that urgent action was needed by governments to secure the health of the people. Following the Health for all 2000 Project, the next year WHO started to challenge the pharmaceutical corporations via publishing 200 cheaper versions of the 5000 branded drugs that were sold at a higher price. However, the position of the WHO changed in the late 1980s and early 1990s. The regulation attempts of the WHO on the private sector, and especially on the pharmaceutical corporations, had an important impact on the change of its position in the 1980s and 1990s. In 1985, US cut back its contributions to the WHO and the budget of WHO was frozen from 1980 onwards. (John Lister, *Health Policy Reform: Driving the Wrong Way?*, (Middlesex :Middlesex University Press, 2005), 68.)

systems of countries with diverse historical and institutional health care arrangements. This led some to argue that that a convergence was taking place among different health care systems across the world.[12] What were the basic common features of these global health care reforms that led some to argue that there was a global convergence of health care systems? The reforms were put on the agenda of different countries to strengthen market mechanisms as a solution to a "crisis" in health linked to the pressures of rising demand and containing costs. Reform packages were introduced in both developed and developing countries with diverse health systems and political contexts. All these reform packages included interventions in the financing, provision, and regulation of the health care system.

Health reform themes and trends were presented under three headings by the WHO: the changing role of state and the market in health care; the reorganization of the system through decentralization, recentralization, and privatization; and patient empowerment and the evolving role of public health.[13] In the health care policy literature, the elements of global health care system are listed as the restructuring of social security systems, the separation of financing and provision, the encouragement for the involvement of non-public institutions and actors, more frequent use of market mechanisms, and decentralization.[14]

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12 Giuliano Bonoli, Vic George and Peter Taylor-Gooby, "Politics Against Convergence? Current Trends in European Social Policy," *Swiss Political Science Review* 2, no.3 (1996): 1-17. cited in Claus Wendt et.al "Convergence or Divergence of OECD Health care Systems" in *International Cooperation in Social Security : How to Cope with Globalisation,* eds., Bea Cantillon and Ive Marx (Antwerpen: Intersentia, 2005), 1; M. Moran, "The Health Care State in Europe: Convergence or Divergence?" *Environment and Planning: Politics and State* 10, no.1 (1992):79. Cited in Tuğba Ağartan, "Turkish Health System in Transition: Historical Background and Reform Experience (PhD Diss., State University of New York, 2008), 42.

13 R. B. Saltman, and J. Figueras, *European Health Care Reform: Analysis of Current Strategies* (Copenhagen:WHO Regional Office for Europe,1997).

14 A. Green, "Reforming the Health Sector in Thailand: The Role of Policy Actors on the Policy Stage" *International Journal of Health Planning and Management* 15 (2000): 39-59 and H. Standing, "Frameworks for Understanding Gender Inequalities and Health Sector Reform: an Analysis and Review of Policy Issues," Working paper series, No. 99.06. Harvard Center for Population and Development Studies, 1999. Cited in Tuba Ağartan, "Sağlıkta Reform Salgını,"

Even though health care reforms across the world have fundamental elements in common, as summarized above, the reform packages and their consequences differed depending on the health system and political context of the country in which they were applied. Hence, to better grasp the trajectory of global health care reform, the next section discusses differing health systems in countries with and without mature welfare states. This section on different health systems and reform experiences across the world will also provide the necessary foundation for situating Turkish health care reform in a global context.

§ 2.2 Typologies of Health Care Systems

2.2.1 *Health Care systems and Reforms in Countries with Mature Welfare States*

There are various health care system classifications in the comparative health policy literature. Each of these classifications depends on the aspect of the health system on which they focus. Scholars that adopt Esping-Andersen's[15] welfare regime typology, such as Ranade,[16] divide the health system into three groups in terms of financing and regulation. Examples include Beveridge systems where the system is centralized and tax-funded, Bismarckian systems where the system is based on social insurance, and private systems where financing is based on private insurance and service provision is mainly private, as well.[17] Ranade adds a fourth called "semashko" regimes that were present in the Soviet Union from the 1920s until 1989 and were characterized by state-funded centralized financing.

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in *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007), 47.

15 Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism*, (Princeton, New Jersey: Princeton University Press, 1990).

16 Wendy Ranade, Introduction to *Markets and Health Care: A Comparative Analysis* (Essex: Longman,1998).

17 John Lister, *Health Policy Reform: Driving the Wrong Way?*, (Middlesex :Middlesex University Press, 2005), 142.

In this chapter, the OECD categorization of health care systems will be used. It is similar to that of Ranade and identifies three main systems in health care based on the criteria of financing, National Health Services (Beverdige), social insurance (Bismarckian), and private insurance.[18] The classification of health services into these three - Beveridge, Bismarckian, and private insurance --is a typology based on the experiences of more developed, wealthier economies.[19]

The Beveridgian system takes its name from the 1942 Beveridge report that paved the way for the National Health System (NHS) in the United Kingdom.[20] The Beveridge system is characterized by universal coverage of all citizens and is financed by the general budget, mainly through tax revenue. Financing and provision are secured by the state. The United Kingdom, Sweden, Spain, Italy, Denmark, Norway, and Portugal are the states where Beveridgian health systems were established after World War II.

In the Bismarckian system, the purchaser and provider are separate. Unlike Beveridge type health care systems, financing is through compulsory insurance premiums gathered from employers and employees. The insurer is in most cases a public body. The provision is purchased by the insurer from public and private providers. The system is called Bismarckian as the first compulsory sickness insurance was passed in Germany by Otto van Bismarck in 1883

18 Tuğba Ağartan, "Turkish Health System in Transition: Historical Background and Reform Experience (PhD Diss., State University of New York, 2008), 39.

19 John Lister, *Health Policy Reform: Driving the Wrong Way?* (Middlesex :Middlesex University Press, 2005), 143.

20 The report stated that "The plan covers all citizens without upper income limit, but has regard to their different ways of life". The report under the heading of social security covered unemployment and disability benefits, pensions, medical treatments and establishment of a ministry of social security. As for medical treatments it was stated that "Medical treatment covering all requirements will be provided for all citizens by a national health service organized under the health departments…" William Beveridge , "Social Insurance and Allied Services." (London: HMSO, 1942), 10-11.

and made membership in previously voluntary funds compulsory for workers.[21] Germany was the first country where this system was embraced;[22] the Netherlands, Luxemburg, Austria, Belgium, and France others where the Bismarckian system has been embraced.[23]

In the private insurance model, financing is through contributions paid either by individuals or employers to private insurers. Service providers are privately owned, as well. The United States, where 70percent of insurers are private, best represents this system. Other countries with private funding and private provision are Australia and New Zealand.

All three of the main health care systems introduced above underwent major reforms in the post-1980 period. The following discussion offers the basic characteristics of these reforms through review case countries.

2.2.1.1 Health Care Reform in the NHS system

Starting with the Beveridgian system, health care reforms in Britain were initiated in 1988 by Margret Thatcher. The justification was presented as a crisis in the NHS reflected in the problem of funding public hospitals. This crisis in the system was announced in a speech by the health secretary[24] that identified several issues as indicators of the crisis in the NHS.[25]

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21 R. B. Saltman, and J. Figueras, *European Health Care Reform: Analysis of Current Strategies* (Copenhagen:WHO Regional Office for Europe,1997), 117.

22 The German health care system is based on statuary insurance, which depends on earnings. Ninety per cent of the population is covered by statuary insurance, and financing is assured almost exclusively by contributions from fixed percentage of gross wages. Thomas Gerlinger, "Health Care Reform in Germany," *German Policy Studies* 6, no. 1 (2010): 107-142.

23 While the Latin American, Turkish and Israeli health systems are closer to the Bismarckian model, it is preferable to classify them in a different heading due to differences in their political and historical contexts in terms of development of the welfare state.

24 Chris Ham, "The United Kingdom" in *Health Care Reform: Learning From International Experiences,* ed. Chris Ham (Buckingham and Philadelphia: Open University Press, 1997), 46.

25 These included the cases of children being denied heart operations because of resource shortages and lack of specialist facilities; long waiting times for non-urgent hospital treatment; the uneven quality of care for elderly people, people with mental illnesses and learning disabilities, and evidence of wide variations in performance within the NHS. Chris Ham, "The United

Health reform entailed marketization and privatization of the NHS, which some regarded as antithetical to the spirit of a health system that was viewed as part of the British national character.[26] While before the reforms the provider and funder of health care was the same body - the state -, the reform separated the provider and funder. In addition, internal markets were created through which state hospitals began to compete like market actors.

These changes introduced in the NHS were part of the "new public management" (NPM) techniques of the governing Conservative Party. The main emphasis of the "new public management" was "the three E's" : economy, efficiency, and effectiveness.[27]

In line with the NPM, private management of health facilities was introduced following the recommendations of the Griffith Report of 1983. This report significantly broke with earlier syndicalist and corporatist methods of management that made it possible for doctors to be managers and to block changes that were introduced. The changes introduced by the report brought about a conflict between managers and doctors.[28]

In terms of private insurance, there was an increase in the privately insured after 1979 when the conservatives came to power in Britain.[29] The increase in the use of private health care can also be explained by the fact that health services were purchased rather than provided by the NHS in the 1980s. Thus, the state became a purchaser rather than a provider of health services.

The decrease in spending and decrease in the percentage of health care in the GDP were also evident in Britain after the 1980s. However, this feature is not unique to the NHS: the percentage increase in health spending in the

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Kingdom," in *Health Care Reform: Learning From International Experiences,* ed. Chris Ham (Buckingham and Philadelphia: Open University Press, 1997), 46.

26 Alan Cribb, "Organizational Reform and Health-care Goods: Concerns about Marketization in the UK NHS", *Journal of Medicine and Philosophy* 33, no. 3 (June 2008) : 222, https://doi.org/doi: 10.1093/jmp/jhn008.

27 Wendy Ranade, *Markets and Health Care: A Comparative Analysis* (Essex: Longman, 1998), 104.

28 Ibid, 104.

29 Michael Calnan and J. Gabe eds., *The New Sociology of the Health Service* (London: Routledge, 2009), 3.

OECD nations as a whole in the 1980-2000 period is a quarter of what it was in 1960-80.[30] Among the reasons, according to Hacker, was the decline of professional power.[31] In Britain, Thatcher assaulted the consultative role of the British Medical Association.[32] Additionally, as the NHS was funded by general tax revenues, its budget was tightened in the early 1980s and in the 1990s.

The election of a Labour Government in 1997 did not bring about a return to the pre-Thatcher health system. Given that a left-of-center government could follow a market road, the coalition of conservatives and liberal democrats established in 2010 unsurprisingly went further in both ideological and policy terms down the road of privatization.[33]

2.2.1.2 Health Care Reform in Former Bismarckian Countries

Bismarckian health care systems are systems where "the supply of health care is partially private and partially public, and most often guarantees the patients free choice of doctor as well as the status of liberal practice of medicine. Expenses are mainly assumed by the different health insurance funds and financed by social contributions."[34] In this section, the reform processes of the German, Dutch, and French systems will be outlined. However, it should be kept in mind that these three systems differ with respect to the way their insurance schemes are organized.

As the government does not directly control health care expenditures, in the systems, health insurance deficits and cost containment were priorities for health care reform agendas.[35] The defining characteristic of health reform in

30 Jacob S. Hacker, "Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform," *British Journal of Political Science* 34, no. 4 (2004): 699, DOI: 10.1017/S0007123404000250.

31 Ibid, 700.

32 Ibid, 701.

33 Gavin Mooney, *The Health of Nations: Towards a New Political Economy* (London; New York: Zed Books, 2012), 68-69.

34 Patrick Hassenteufel and Bruno Palier, "Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems," *Social Policy and Administration* 41, no. 6 (December 2007): 576, https://doi.org/10.1111/j.1467-9515.2007.00573.x.

35 Ibid, 580.

Germany was cost containment, which started with "Cost Containment Act" of 1977.

> In Germany, cost containment policies followed the historical pattern of self administration, being negotiated between sickness funds and the doctors' unions (Hassenteufel 1996) yet as early as 1975-1976 unions signed agreements with the sickness funds which included a limitation on price rises for medical acts.[36]

The principle of cost containment in Germany was an "income-oriented expenditure policy" to guarantee stable contribution rates.[37] But the aim was to lower employers' contributions, and to realize this, the costs of illness were privatized.[38] This policy was not unique to Germany and could be observed in the Netherlands and France in the same decade.

However, the increase in social contributions to insurance in the 1980s was not enough for the cost-containment targets; thus, the aim became to decrease the growth of health insurance expenditures and reduce the deficits of the health insurance funds.[39] According to Palier, the cost-containment policies of Bismarckian systems can be summarized by two characteristics: the introduction of a capped budget for health expenditures and a decrease in health risk coverage.[40]

In 1992, following German unification, new measures were enacted that imposed a shift of Germany the health care system paradigm: the Health Care Structure Act. The changes brought about by this act were furthered by the

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36 Ibid, 582.

37 Reinhard Busse and Annette Riesberg, *Health Care Systems in Transition: Germany* (Cophenagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004), 186.

38 Thomas Gerlinger, "Health Care Reform in Germany", *German Policy Studies* 6, no. 1 (2010): 118-119.

39 Patrick Hassenteufel and Bruno Palier, "Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems," *Social Policy and Administration* 41, no.6 (December 2007): 582, last accessed December 10 2014, https://doi.org/10.1111/j.1467-9515.2007.00573.x.

40 Ibid, 582.

efforts of the SPD/Green Coalition of 1998-2005 and the CDU/CSU/SPD coalition that followed it.[41] In 1995, the main characteristic of the paradigm shift was a turn towards competition-centered structural reforms along with cost containment.[42] In 1997, the Health Insurance Contribution Rate Exoneration Act was embedded in a broader act in support of economic growth. Its cost-containment measures were less strict than previous acts.[43]

The competition introduced among sickness funds diversified with the 2007 Health Reform that allowed these funds to offer lower contribution rates to clients who were willing to pay more of their treatment costs out-of-pocket.[44] This was a step away from universal coverage that guarantees the health care of all citizens but at the same time leaves the choice of insurance to the citizens that depended on their ability to pay.

In the Netherlands, where the health care system was partly similar to that of Germany, discussions on cost-containment measures for health care started during the same period in the early 1970s. From 1941 until 1986, 30 percent of the population of the Netherlands relied on private insurance. In 1986, high earners were excluded from public health care coverage.[45] Until 1986, there were two compulsory schemes - for the employed and the elderly - and a voluntary scheme for the remaining population, the eligibility for which depended on earnings. The self-employed were able to choose between public coverage, a voluntary scheme, or no coverage at all.[46]

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41 Thomas Gerlinger, "Health Care Reform in Germany", *German Policy Studies* 6, no.1 (2010):113.

42 Ibid, 135.

43 Reinhard Busse and Annette Riesberg, *Health Care Systems in Transition: Germany* (Cophenagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004), 192.

44 Thomas Gerlinger, "Health Care Reform in Germany," *German Policy Studies* 6, no. 1 (2010): 119.

45 Sarah Thomson and Elias Mossialos, "Choice of Public or Private Health Insurance: Learning from the Experience of Germany and the Netherlands," *Journal of European Social Policy* 16, no.4 (November 2006): 314-316, https://doi.org/10.1177/0958928706068271.

46 Ibid, 319.

In the Netherlands, cost-containment measures were initially discussed following the oil crisis of the mid-1970s. The "1974 White Paper on the Structure of Health Care" was the first step in health system reform, and as in Germany, the main concern was controlling increasing costs in the health sector.

The most significant characteristics of reform in Netherlands[47] were the growing control of the government over the health sector, the shift of service provision from care hospitals to primary care, and the strengthening primary care facilities. A single national health insurance was proposed but rejected.[48]

> The Dutch case illustrates how the reform agenda slowly moved from cost containment issues to more structural ones, aimed at changing the governance of the system. The reforms adopted since the mid-1990s

47 In 1986, high earners who had since 1941 had the choice to be part of the compulsory scheme were excluded from this compulsory public coverage.In addition to this the compulsory scheme for elderly people and the voluntary scheme for the self employed were abolished and they were transferred into a compulsory scheme. Since 1989 all the people over the age of 65 and students have been eligible for financial assistance. (Sarah Thomson and Elias Mossialos, "Choice of public or private health insurance: learning from the experience of Germany and the Netherlands," *Journal of European Social Policy* 16, no.4 (November 2006) : 316-321, https://doi.org/10.1177/0958928706068271.)

Budgetary precautions were taken as well; for example in 1983 open-ended hospital reimbursement was replaced by a global budgeting system as well as the limiting of the purchase of expensive equipment, along with restriction of fees and salaries. After 2002 and within the framework of reducing the coverage of mandatory health insurance, several benefits were excluded from sickness funds, and these have to be covered by out-of-pocket payments by patients. With the 2005 health reform in the Netherlands health insurance became compulsory for all. Patrick Hassenteufel and Bruno Palier, "Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems," *Social Policy and Adminstration* 41, no.6 (December 2007): 577-584, https://doi.org/10.1111/j.1467-9515.2007.00573.x.

48 W. Schäfer, M. Kroneman, W. Boerma, M. van den Berg, G. Westert, W. Deville et al. *The Netherlands, health system review* vol:12, no. 1 (Cophenagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2010).

> have led to structural changes which are partly blurring the difference between health insurance and national health systems.[49]

Even though the French health care system has a more universal character than the Dutch and German examples, it converges with them in terms of its reliance on employment for access to health care. Again cost-containment measures were the instigating discussion for health care reform.

Health insurance is the heart of the French social protection system: "securité social" means first of all health services for the people. Access to health services are based on employment, contributions are paid by the employer and employee together and administration is conducted via para-public bodies, namely the sickness funds.[50] The WHO defines the French health system as between the Beveredgian and Bismarckian systems as it has strong state intervention alongside sickness funds; public and private health insurances are thus combined in the French system.[51]

Reforms that took place from the 1990s until 2009 focused on cost containment with measures such as setting ceilings for expenditures, pharmaceutical plans, extending the number of people channeled toward voluntary health insurance, and regulating the voluntary health insurance market. In addition to cost-containment and market-oriented reforms, equity in geographic distribution was among the major components of reform in the French health care system.

In sum, this section provided an overview of health care systems and reforms in countries with mature welfare states. As the discussion highlighted, cost-containment along with marketization was a primary objective of health care reforms in many of these countries. Yet, as underscored in the relevant literature on global health care reform, health care reforms across the world

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49 Patrick Hassenteufel and Bruno Palier, "Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems," *Social Policy and Administration* 41, no. 6 (December 2007): 586, https://doi.org/10.1111/j.1467-9515.2007.00573.x.

50 Ibid, 575.

51 K. Chevreul et al, *France: health system review* Health Systems in Transition 12, no. 6, (Cophenagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2010), 221.

have not all been characterized by the primary aim of cost reduction, leading to decreases in health care spending and shrinkage of coverage.[52]

On the contrary, there were different challenges and objectives for countries without mature welfare states where health care coverage was historically limited. The next section turns to a discussion of such countries in South Asia and Latin America, the health care systems and reforms of which resemble those of Turkey.

2.2.2 *Health Care Systems and Reform in South Asian and Latin American Countries*

While, as discussed, health policy reforms around the world took place simultaneously and had similar characteristics, they differed depending on the context in which they emerged. In this respect the Turkish experience, despite differences stemming from its own peculiar political, social, and economic context, is not unique. Turkey's experience resembles those of some countries more than others, and most of the similarities stem from similar pre-reform structures in those countries.

The historical existence of a fractured social security system resulting in unequal access to services and the need to increase coverage are among the most visible resemblances of the contexts that are similar to those of Turkey. The difference from that of the mature welfare states is that the introduction of market elements into the health care sector came hand in hand with the abolition of unequal access to health care services as well as with the objective of increasing coverage.

Ağartan summarizes the challenges that countries without mature welfare states faced in reforming their health care systems as follows:

> The reform proposals announced by governments in late-developing countries, like Turkey and Mexico, or transition countries, like Macedonia, similarly combine…elements of marketization and NPM. Yet, in these countries, which have not created universal health care systems, governments are faced with different challenges. Many of these

52 Çağlar Keyder, Giriş (Introduction) to *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007), 8.

> health care systems suffer from inadequate insurance coverage; lack of comprehensive benefits packages; barriers to access due to harsh geographic and weather conditions; massive migration to urban centers; significant problems in the distribution of health care resources, including facilities, equipment and personnel; prevalence of informal practices such as transfer of patients to private offices of physicians or informal payments to providers, which lead to major inequities.[53]

This section reviews case countries similar to Turkey that faced such challenges in reforming their health care systems. These include Latin American countries such as Mexico and Chile and Southeast Asian countries such as South Korea and Malaysia.

In Southeast Asia, there was no universal coverage in health care systems (except for Malaysia and Thailand), and one aims of health care reforms was to achieve universal coverage.[54] In addition, market reforms and the encouragement of competition in the health sector went hand in hand with struggles to overcome epidemic diseases such as HIV.

The South Korean health care system took those of Japan and United States as models, and its health insurance system was put in place in the late 1970s.

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53 Tuba Ağartan "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60, no. 4 (2012): 457, https://doi.org/10.1177/0011392112438331. For further discussion see: Bistra Vladimirova Datzova "The Difficult Transition to National Health Insurance in Bulgaria," *Journal of International Development* 18, no.2 (2006): 425–434, https://doi.org/10.1002/jid.1292; Julio Frenk, "Dimensions of Health System Reform," *Health Policy* 27, no. 1 (1994): 19-34; Anwar Islam and M. Zaffar Tahir, "Health Sector Reform in South Asia: New Challenges and Constraints," *Health Policy* 60, no.2 (2002):151-169; Robert Nordyke and John Peabody, "Market Reforms and Public Incentives: Finding a Balance in the Republic of Macedonia," *Social Science and Medicine* 54, no. 6 (April 2002): 939–53; Richard Saltman and Joseph Figueras, *European Healthcare Reform: Analysis of Current Strategies: WHO Regional Publications, European Series,* No. 72. (Copenhagen: World Health Organization, 1997).

54 Viroj Tangcharoensathien, Walaiporn Patcharanarumol, Por Ir, Syed Mohamed Aljunid, Ali Ghufron Mukti, Kongsap Akkhavong, Eduardo Banzon, Dang Boi Huong, Hasbullah Thabrany, Anne Mills," Health Financing Reforms in Southeast Asia: Challenges in Achieving Universal Coverage" *Lancet* 377 (5 March 2011): 864, doi: 10.1016/S0140-6736(10)61890-9.

The system consisted of multiple funds that were later unified into a single insurer in the late 1980s.[55] Universal coverage was achieved in 1989 by the National Health Insurance.[56] In 2000, two main reforms were: the separation of the prescription and distribution of drugs, and as mentioned above, the integration of multiple health insurers into a single payer.[57] According to Sun-Jeong, the public-private mix is an important feature of the South Korean health care system as public payment of private services is implemented at high levels compared to European counterparts, and the management of the supply side is performed privately.[58]

The impact of the reform (SPD) on the public-private mix was significant due to the changing policy on the sale of pharmaceuticals. The shift in sales from physicians to pharmacies paved the way for an increase in payments made by the public - the reform increased public spending on health care by 8.3%[59] - to private providers , that is pharmacies. Even though this shift took place gradually from 1999 to 2005, implementation was not easy as there was pressure from physician groups and pharmacists seeking to protect advantages at risk due to this separation.[60]

As for the merger of the insurance funds, the National Health Insurance Corporation was established in 2000, and in 2003 the finances were merged.[61] The other dimension of the health reform in South Korea was a long-term care scheme introduced in response to a rapidly ageing population.

The South Korean health reform experience is similar to that of Turkey. The reform, which was finalized in 2000, resulted in a national health insurance with a single payer system where diverse insurance societies were unified.

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55 C.B Chun, S.Y Kim, J.Y Lee and S.Y Lee, *Republic of Korea: Health system review. Health Systems in Transition 11, no.7* (Copenhagen: World Health Organization, 2009), 136.

56 Hyoung-Sun Jeong, "Health care reform and change in public–private mix of financing: a Korean Case," *Health Policy* 74, no. 2 (2005):133.

57 Ibid, 134.

58 Ibid, 134.

59 Ibid, 139.

60 C.B Chun, S.Y Kim, J.Y Lee and S.Y Lee, *Republic of Korea: Health system review. Health Systems in Transition 11, no.7* (Copenhagen: World Health Organization, 2009), 137.

61 Ibid, 141.

Before then, like in Turkey, the coverage of citizens was divided into three types of insurance scheme: for industrial workers, teachers and government employees, and the self-employed. The driving force of the reform was to abolish inequity among health care insurance societies and the consequences of their differing financial abilities.[62] Following the reform, the NHI experienced a fiscal crisis that resulted from rapid increases in health expenditures resulting from the separation of financing and provision and the dominance of private providers in the health sector.[63] As the next section will make clear, the increased share of private hospitals as providers of health care is also a phenomena observed after the reform in Turkey.

Malaysia is another case among South Asian countries that deserves discussion in terms of its implications for evaluating the Turkish health care reform. Health in the Malaysian context was important for a healthy, productive workforce that was the main source of economic growth. The Malaysian state, according to Chan Chee Khoon, cannot be considered a welfare state but rather a guardian state. Keeping infectious diseases under control was one of the steps made to maintain a healthy population.[64] Another significant feature of the Malaysian health care system was its aim to appeal to an overseas clientele; thus, the private sector on which the system is increasingly based does not only serve locals.

In 1996, hospital support services were privatized and awarded to three local consortia in a joint venture with foreign partners in an exercise with little transparency and accountability and few competitive tenders.[65] Khoon states that public sector health care delivered impressive value for money improve-

62 Soonman Kwon, "Healthcare Financing Reform and the New Single Payer System in the Republic of Korea: Social Solidarity or Efficiency?" *International Social Security Review* 56, no. 1 (2003) :75-94.

63 Soonman Kwon, "The Fiscal Crisis of National Health Insurance in the Repbublic of Korea: In Search of a New Paradigm," *Social Policy and Administration* 41, no. 2 (2007): 162-178.

64 Chan Chee Khoon, "Political Economy of Health Care reforms in Malaysia," in *Restructuring Health Services: Changing Contexts and Comparative Perspective,* ed. Katsuri Sen. (London; New York: Zed Books, 2003), 200.

65 Ibid, 202-203.

ment, accounting for less than 2 percent of the GDP. Thus it is difficult to justify privatization on the basis of cost containment or that health was a burden on the public budget.[66] Excessive expensive medical equipment purchases by private hospitals have been noted, and the number of MRI machines in central Kuala Lumpur is equal to that for the whole of Australia. The entry of foreign insurance companies followed the East Asian currency crisis and worked as a support to the financial situation.[67]

Khoon concludes that the motivation for the privatization of the Malaysian health care was not decreasing burdensome public expenditures but rather a negotiated interaction among connected Malaysian entities that consider the receding of the state to be a business opportunity.[68]

Apart from the two South Asian cases discussed above, two cases from Latin America – that of Chile and Mexico – are also relevant for thinking about Turkish health care reform from a comparative perspective.

The Chilean experience of health care reforms dates to the Pinochet era where the creation of the FONASA (National Health Fund) separated health care provision from financing.[69] Following challenges stemming from the deterioration of public health services, especially to the disadvantaged in rural areas and poor urban districts, certain measures were taken. These included the establishment of guarantees for certain groups, the creation of separate benefit packages, and a dual health care system - a consequence of neoliberal reforms undertaken in the 1970s -, which created a biased health care service to the disadvantage of the most vulnerable of the population.[70] The question around which recent Chilean health sector discussions revolve is why center-left coalition governments in the 1990-2010 period did not pursue paths that would put the private sector under state or consumer control.[71]

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66 Ibid, 203.

67 Ibid, 207.

68 Ibid, 208.

69 E. Rotarou and D. Sakellariou "Neoliberal Reforms in Health Systems and the Construction of Long-lasting Inequalities in Health Care: A Case Study from Chile," *Health Policy* 121, no. 5 (2017) :498.

70 Ibid, 495-503.

71 M. Martinez-Gutierrez and C. Cuadrado, "Health Policy in the *Concertacion* Era (1990-2010): Reforms the Chilean way," *Social Science & Medicine* 182 (June 2017) : 117-126.

Even though the reform process was not identical to that of Turkey, it is possible to draw similar conclusions in terms of private sector inclusion in health care provision and the eventual stratification among different segments of society depending on income (the wealthy having the option to opt into private health insurance schemes to improve the services they receive). A statement by Ewig on the Chilean case can also be applied to the Turkish health reform experience in terms of the inclusion of marketization elements in the health sector: "Once for-profit providers are stake-holders in social policy systems, it may be very difficult to reverse their inequitable effects."[72]

The Mexican health care reform that took place in the 2001-2006 period created a national health insurance system (Seguro Popular) that replaced fragmented health insurance schemes while at the same time increasing the number of insured and decreasing inequality in access to health care.[73] The lack of infrastructure and human resources to accompany this health reform in Mexico, as well as a lack of information given to providers and citizens regarding the insurance system, resulted in failures at the implementation stage. But despite challenges in the implementation phase that included non-payment of user fees and premiums by citizens, political support for the PHI reform continued and appealed to lower-class voters. Even though most did not have guaranteed access to services, they had more services compared to the pre-PHI era.[74]

Parallels can be drawn between the Turkish and Mexican experiences in the respect of the creation of a health insurance system without sufficient infrastructure and human resources - and despite this, the high satisfaction of the people and the translation of this satisfaction into electoral success. Un-

72 C. Ewig C. and G. A Palmucci, "Inequality and the Policies of Social Policy Implementation: Gender, Age and Chile's 2004 Health Reforms" *World Dev*. 40 no.12 (2012): 2490-2504 cited in M. Martinez-Gutierrez and C. Cuadrado, "Health Policy in the *Concertacion* Era (1990-2010) : Reforms the Chilean way" *Social Science & Medicine* 182 (2017) :125.

73 Felicio Knaul and Julio Frenk, "Health Insurance in Mexico: Achieving Universal Coverage through Structural Reform," *Health Affairs* 24, no.6 (2005): 1467-1476.

74 Jason Lakin "The End of Insurance? Mexico's Seguro Popular, 2001-2007," *Journal of Health Politics, Policy and Law* 35, no. 3 (June 2010): 314-352.

derstanding the parallel dynamics between Mexico and Turkey requires a detailed discussion of the health care system in Turkey and the reform it underwent after the introduction of the HTP, a discussion that is offered in the next section.

§ 2.3 The Turkish Health Care System and Reform in Global Context

2.3.1 *Turkish Health Care System before the HTP*

Turkey's social security regime has historically been classified as an inegalitarian, corporatist, Bismarckian system in which pension and health care benefits were linked to occupational status.[75] This hierarchical social security system

75 Ayşe Buğra, and Çağlar Keyder. "The Turkish Welfare Regime in Transition," *European Journal of Social Policy* 16, no. 3 (August 2006): 212, https://doi.org/10.1177/0958928706065593; Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey," *Middle East Law and Governance* 2, no.2 (January 2010): 152-184. https://doi.org/10.1163/187633710X500739; Ayşe Buğra and Ayşen Candaş "Change and Continuity under an Eclectic Social Security Regime: The Case of Turkey," *Middle Eastern Studies* 47, no.3 (May 2011): 515-528. https://doi.org/10.1080/00263206.2011.565145; Tuba Ağartan, "Sağlıkta Reform Salgını" in *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et. al. (İstanbul: İletişim Yayınları, 2007), Tuba Ağartan "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60 no. 4 (2012): 456-471, https://doi.org/10.1177/0011392112438331; Tim Dorlach, "AKP between Populism and Neoliberalism: Lessons from Pharmaceutical Policy," *New Perspectives on Turkey* 55 (November 2016): 55-83, https://doi.org/10.1017/npt.2016.23; Volkan Yılmaz, "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey,* Volume: 48 (March 2013): 55-77, https://doi.org/10.1017/S0896634600001886; Volkan Yılmaz, *Politics of Healthcare Reform in Turkey* (London:Palgrave Mc Millan, 2017); Tuğba Ağartan, "Turkish Health System in Transition: Historical Background and Reform Experience (PhD Diss., State University of New York, 2008); Asena Günal, "Health and Citizenship in Republican Turkey: An Analysis of the Socialization of Health Services in Republican Historical Context" (PhD Diss., Boğaziçi University, 2008); Bengi Demirci, "Transformation in the Organizational and Financial Set-up of the Health Care System in Turkey: Its Repercussions and Similarities with the English Model" (PhD Diss., Middle East Technical University 2012).

for the formally employed was accompanied by informal mechanisms of welfare provision extended by the state in addition to a high level of familialism observed in social protection. These historical features of its social welfare led to the classification of Turkey within the cluster of Southern European Welfare Regimes.[76]

Thus, the health care system of Turkey before the introduction of the Health Transformation Program was fragmented and inegalitarian. Health care coverage of citizens was directly linked to the social security fund to which they belonged, which depended on their occupational status. The three public social security funds - namely the Emekli Sandığı (Retirement Fund), Sosyal Sigortalar Kurumu (Social Insurance Institution), and Bağ-Kur (Insurance Fund for Craftsmen, Artisans and other Self-Employed individuals) had major differences in terms of the payment of premiums, the health facilities to which they provided access, and the extent of their coverage. In this system, the most advantageous were the ones covered by the Retirement Fund - a fund for state employees.[77]

Inequalities among public insurance funds were not the only problem that defined the health care system before its reform. There was also the major problem of coverage. The three public funds covered only the formally employed, though high levels of informal employment were a defining historical feature of the labor market in Turkey. Given this informality, large segments of the population were not covered under the health care system, exclusion that was reflected in statistics just before the implementation of the HTP. Right before its announcement, the National Household Health and Expenditure

76 Ayşe Buğra, and Çağlar Keyder. "The Turkish Welfare Regime in Transition," *European Journal of Social Policy* 16, no.3 (August 2006): 212. https://doi.org/10.1177/0958928706065593.

77 Üstündağ and Yoltar state that health is an area where the hierarchies among the different citizenship statuses are created in Turkey. They emphasize that in the pre-reform health-care system in Turkey the hierarchies that are set among the members of these different social security funds reflect that the state made the largest investment on the state employees and qualified. Nazan Üstündağ, and Ç. Yoltar, "Türkiye'de Sağlık Sisteminin Dönüşümü: Bir Devlet Etnografisi" in *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et. al. (İstanbul: İletişim Yayınları, 2007), 55-94.

Survey revealed that 23.3 million people, which corresponded to 32.79% of the population, were without any health coverage.[78]

Given the problem of coverage, the state introduced the Yeşil Kart (Green Card) in 1992 which was a means-tested scheme financed by the general budget. This program extended health care to the eligible poor, but the benefit package was limited in comparison to those offered by the three public insurance funds.

Despite early historical efforts to change the system into a more egalitarian one through the socialization project of the 1960s[79] and later attempts to extend coverage through the introduction of the Green Card scheme in the 1990s, inequalities in the health care system persisted. Social inequalities that defined the health care system before the HTP are summarized by Yılmaz as follows: "Inequalities among beneficiaries of the three public insurance schemes; inequalities between the publicly insured and the uninsured sections of society (including green card users and people without insurance) and inequalities arising from informal payments in health-care provision."[80]

The informal payments that Yılmaz identifies as one source of inequality in the pre-HTP health care system - which in 2002 constituted 25% of out-of-

78 "Türkiye Ulusal Sağlık Hesapları Hane Halkı Sağlık Harcamaları 2002-2003" (İstanbul:Refik Saydam Hıfzısıhha Merkezi Başkanlığı, 2006), 16. In the same survey, statistics for those covered in healthcare were as follows:: 33.4 % of the population covered by the SSK (active and retired),12.5% by Emekli Sandığı (including the active state employees), 11.7% by BAĞKUR (active and retired), 8.6% by yeşil kart, 1% by private insurance and other schemes and 32.8% are not covered.

79 Following the 27th May 1961 military coup, State Planning Organization and the military proposed the socialization project which was designed by Nusret Fişek in order to increase the reach of the health services to until-then excluded parts of the population. The emphasis was on abolishing the disparities among the rural and urban areas alongside a focus on population planning. As Günal states from the beginning, socialization was a project that aimed to increase the access to preventive health care services in the until then deprived areas. Asena Günal, "Health and Citizenship in Republican Turkey: An Analysis of the Socialization of Health Services in Republican Historical Context" (PhD Diss., Boğaziçi University,2008), 385.

80 Volkan Yılmaz, "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey* 48 (March 2013): 61.

pocket payments in health[81]- included informal payments to providers in hospitals or the transfer of patients to physicians' private offices. Poor patients and Green Card holders were most affected by out-of-pocket and informal payments in health care.[82]

In addition to social inequalities, the health care system before the HTP was characterized by regional inequalities[83] reflected in the disparate distribution of resources and medical staff between urban and rural areas and eastern and western regions.[84]

Thus, both the inegalitarian structure of the health system and the criticisms of it were already present at the time the HTP was announced. The intermingling of structural changes that the AKP insistently introduced to the health system through the HTP as well as a strong discursive determinacy to promote these changes as an end to the inequalities of "Old Turkey" created a rupture in Turkey's health system and in the larger political field. The next and final section provides an overview of the HTP which served as the basis of the AKP's populism and the political contestation directed to this populism.

81 M. Tatar M, H. Özgen H and B. Şahin et al. "Informal payments in the health sector: A case study from Turkey," *Health Affairs* 26, no.4 (2007): 1029–1039, cited in Tuba Ağartan "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60 no. 4 (2012): 461.

82 SN Sülkü and DM Bernard, "Financial Burden of Healthcare Expenditures in Turkey 2002–2003," Agency for Healthcare Research and Quality Working Paper, No. 09004 (2009), www.meps.ahrq.gov/mepsweb/data_files/publications/workingpapers/wp_09004.pdf. cited in Tuba Ağartan "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60 no. 4 (2012): 462, and cited in Volkan Yılmaz, "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey* 48 (March 2013): 64.

83 Tuba Ağartan "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60 no. 4 (2012): 463.

84 For further discussion see: World Bank, *Turkey Reforming the Health Sector for Improved Access and Efficiency*, Vols I and II, Report No. 24358-TU. (Washington, DC: World Bank. 2003), Ministry of Health, *Transformation in Health*, (Ankara: Ministry of Health, 2003 December).

2.3.2 *Health Reform in Turkey: The Health Transformation Program*

Upon its rise to power, the AKP initiated a reform of health care - the Health Transformation Program – to counter the socio-economic and structural problems discussed in the preceding section. One reason for the AKP's motivation to undertake the reform of health can be explained by domestic, populist politics. Extending health care to segments of the population excluded from health care - which the reform did through the introduction of a general health insurance scheme - had the clear potential to appeal to the electorate of the AKP among whom those without health care constituted a significant constituency.[85]

Yet the reasons for Turkish health care reform cannot be confined to domestic politics; it must be understood in relation to the global context of health care reform[86] discussed in this chapter. Thus, while the AKP, using the powers of a single party government, undertook an unprecedented reform of health care, its agenda was shaped by previous reform proposals in Turkey and the global reform agenda for which the WB was a determining actor.[87]

Given these motives and impinging dynamics, the Turkish Ministry of Health announced the Health Transformation Program in March 2003. The reason behind the title, rather than calling it a reform program, was explained with reference to previous attempts to change health policy in Turkey.

> There have been a number of efforts and projects of the Ministry of Health produced with national and international partnership up to now and these projects have been called 'reform'. We know that the ministry has worked upon many projects, which aim for the same goal. The reason why we are not talking about a reform today is because we are aware of the fact that we are not producing a new point of view in

85 Çağlar Keyder, Giriş (Introduction) to *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007), 22.

86 Ibid, 22.

87 Tuğba Ağartan, "Turkish Health System in Transition: Historical Background and Reform Experience" (PhD Diss., State University of New York, 2008), 282; Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey" *Middle East Law and Governance* 2, no. 2 (January 2010): 169, https://doi.org/10.1163/187633710X500739.

> the field of health. As the Ministry of Health, we should expand the current inherited experience of the civilized world. Thu public however lost confidence in these reforms because similar reform efforts have been unfruitful until now. On the other hand, it is not realistic to move into a completely new system abandoning the current system all at once. In order to achieve this desirable change, it is necessary to alter the existing structure into a planned target without harming the existing one..... Therefore we have launched a set of actions in which all the involved parties will be able to get responsibility in order to light up the ambition of the public, which has already turned into dismay. We call this a 'Transformation Program.'[88]

The components of the transformation of health were listed:

> A Ministry of Health that plans and audits; a general health insurance system that unites everyone under the same roof; an extensive, accessible and smiling health system; strengthened primary health care services and a family physician model; an efficient and gradual referral system; health institutions that have administrative and financial autonomy; a health work force that works with high motivation equipped with knowledge and capabilities; education institutions that support the system; quality and accreditation for qualified and efficient health services; an institutional set-up for reasonable pharmaceutical administration; a health information system.[89]

As discussed in this chapter, countries like Mexico, Chili, South Korea, and Turkey faced different challenges in health care reform. The difference from those of mature welfare states was that the introduction of market elements to the health sector come hand in hand with the abolition of inequality in access to health care services as well as with the objective of increasing coverage.

Thus, as elaborated on in the academic literature on health reform in Turkey (see the introduction), a dual trend characterized the reform in health. On

88 Ministry of Health, *Transformation in Health*, (Ankara: Ministry of Health, 2003 December), 24.

89 Ibid, 26-28.

one hand, there was a universalist trend aimed at both abolishing the inegalitarian structure of the health system and extending coverage. On the other, there was a move to introduce marketization and alter the role of the state in the health system.

These two leading trends led to a series of structural, organizational, and financial changes to the health system. In the publication of the WHO Regional Office for Europe entitled "Strategic Planning for Health: A Case Study from Turkey," the steps made by the AKP governments regarding its Health Transformation Program were listed chronologically based on the yearly publications of the Ministry of Health.[90]

Appendix A is a detailed chronology of the changes introduced by the HTP. As ensuing chapters in demonstrate, each of these individual changes were used as a reference point by the AKP to construct its pro-reform discourse. Some of these individual changes also provided the basis on which contesting actors raised their opposition to the health reform as will be discussed in detail in Chapters 6, 7 and 8.

Here, only major changes introduced to the system are summarized. The universalist trend of the reform sought to eliminate the inegalitarian structure of Turkish health care stemming from its social security structure. The three public insurance funds - the Retirement Fund, Social Insurance Institution and Social Security Institution of Craftsmen, Tradesmen, and Other Self-Employed, were unified to provide a unitary social security scheme to the citizens.

A single-payer system, namely the Social Security Institution (Sosyal Güvenlik Kurumu or SGK), was established, and united the three public insurance funds. An obligatory General Health Insurance (Genel Sağlık Sigortası or GSS) scheme financed through contributions was introduced in which the state would pay for the poor that met the eligibility criteria.

There was also a move toward the unification of the public hospital system. All hospitals - including those that belonged to a particular insurance fund such as those belonging to the SSK or various public institutions such as Turkish Railways - were transferred to the Ministry of Health through a legal

90 Anne S. Johansen, *Strategic Planning for Health: A case study from Turkey* (Copenhagen: World Health Organization Regional office for Europe, 2015), 31.

change that took place in January 2005.[91] Thus, even before the introduction of the General Insurance Fund and SGK, it became possible for people to have access to hospitals to which they did not up until then. In other words, there was theoretically equal access to public hospitals.

The second trend that governed health care reform – marketization - was reflected in changes introduced to the provision of health. Private investment in the health system was encouraged. Thus, there was a significant increase in the number of private hospitals after the launch of the HTP. Private hospitals in 2002 accounted for 271 - or 23.4 percent - of the 1156 hospitals in the country. By 2016, the number of private hospitals reached 565 - 37,4 percent of 1510 hospitals. In the same period public hospitals (those belonging to the Ministry of Health and university hospitals) decreased from 71.2 percent of the total in 2002 to 62.5 percent in 2016.[92]

Another aspect of marketization was the introduction of the split of providers and purchasers. The state became a purchaser of health services from the private sector, and an internal market was created wherein public hospitals compete with private hospitals. As noted by Eder, the share of social security health expenditures received by private hospitals rose by 64% in the 2002-2007 period.[93] The share in December 2017 was 20.3 percent.[94]

An in-depth analysis of the consequences of the reform is beyond the scope of this dissertation. Only major points and arguments raised in the relevant scholarly literature on health reform in Turkey will be presented alongside basic statistics. Although critical, social scientific analyses of the reception

91 "Law no: 5283 on the Transfer of some Public institutions and Organizations to the Ministry of Health" (5283 sayılı Bazı Kamu Kurum ve Kuruluşlarına Ait Sağlık Birimlerinin Sağlık Bakanlığına Devredilmesine Dair Kanun), *T.C. Resmi Gazete* 19 January 2005, no: 25705.

92 Sağlık Araştırmaları Genel Müdürlüğü, (General Directorate of Health Research) "T.C Sağlık Bakanlığı Sağlık İstatistikleri Yıllığı 2016," (Ministry of Health 2016 Health Statistics Almanac) (Ankara: Ministry of Health,2017), 101.

93 Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey" *Middle East Law and Governance* 2, no. 2 (January 2010): 170-171. https://doi.org/10.1163/187633710X500739.

94 SGK (Social Security Institution), Monthly Statistical Bulletin, Health Statistics, Billing Information according to the type of Health Service Provider, December 2017.

of health care reform in Turkey are lacking, some surveys suggest that the reform is highly popular among receivers. Satisfaction surveys of the Turkish Statistical Institute show that the percentage of people highly satisfied with public health services rose from 40 percent in 2003 to 71.7 percent in 2017, and public health institutions rose from last among state institutions in terms of satisfaction to second.[95]

Statistics also reveal that coverage was expanded after the HTP. In 2002, statistics for those covered by health care were as follows: 33.4 percent of the population was covered by the SSK (active and retired), 12.5% by Emekli Sandığı (including active state employees), 11.7 percent by BAĞKUR (active and retired), 8.6 percent by the Green Card scheme, and 1 percent by private insurance and other schemes. 32.8 percent were not covered.[96] Coverage rates in 2016, on the other hand, were as follows: the total of insured people, pensioners, and their dependents account for 85.5 percent of the population and those whose premiums are paid by the state or themselves account for 12.8 percent of the population. This sums to 98.3 percent coverage, which leaves 1.7 percent of the population uncovered.[97] Increases in the number of hospital visits are also reflected in the statistics. Yearly visits in 2002 to the Ministry of Health hospitals were 110 million, which corresponded to 1.58 visits per person. This number reached 340 million in 2016, corresponding to 4.3 visits per person. Visits to private hospitals, on the other hand, rose from 5.6 million a year in 2002 to 71 million in 2016.[98]

Thus, most academic studies on Turkish health reform agree that coverage expanded significantly with the reform. Most studies also emphasize that the

95 TÜİK, "Yaşam Memnuniyeti Araştırması, Genel Olarak Kamu Hizmetlerinden Memnuniyet Düzeyi 2003-2016" (Turkish Statistical Institution, Life Satisfaction Survey, Survey on Satisfaction from Public Services 2003-2016), http://www.tuik.gov.tr/MicroVeri/YMA_2016/ozettablolar/index.html.

96 Refik Saydam Hıfzısıhha Merkezi Başkanlığı, "Türkiye Ulusal Sağlık Hesapları Hane Halkı Sağlık Harcamaları 2002-2003," (Turkey National Health Expenditure Estimates, Household Health Expenditure Survey 2002-2003), 2006, 16.

97 SGK, 2016 Sağlık İstatistikleri Yıllığı, (Social Security Institution 2016 Statistical Yearbook).

98 Kamu Hastaneleri Genel Müdürlüğü, Genel Sağlık İstatistikleri, (General Directorate of Public Hospital Unions, General Health Statistics, http://rapor.saglik.gov.tr/istatistik/rapor/.

abolishment of occupational – and status-based inequalities in the system through the unification of different public insurance schemes was a positive move towards universalism.[99]

However, as already discussed in the introduction, academic studies on the Turkish health reform also raise a series of criticisms about [potential] consequences of the reform. Firstly, there are concerns about the financing of the General Health Insurance scheme through contributions rather than taxes, which critics argue will lead to a problem of coverage since there will be those who will not be able to pay their contribution.[100]

A major line of criticism is directed at the marketization trend of the reform. Some argue that the reform falls short of lifting the fiscal burden on the state since public health expenditures skyrocketed.[101] Public expenditure on health in 2002 was 18.7 million lire corresponding to the 5.2 percent of the gross national product. It reached its peak in terms of percentage of GDP in 2007 at 5.8%, and as of 2016, a public expenditure of 119.7 million lire corresponds to 4.6 percent of the GDP.

99 Çağlar Keyder, Giriş (Introduction) to *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007); Tuba Ağartan "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60 no. 4 (2012): 456-471, https://doi.org/10.1177/0011392112438331; Volkan Yılmaz, "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey,* Volume: 48 (March 2013): 55-77, https://doi.org/10.1017/S0896634600001886.

100 Çağlar Keyder, Giriş (Introduction) to *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds., Çağlar Keyder et.al. (İstanbul: İletişim Yayınları, 2007); Ayşe Buğra, and Çağlar Keyder. "The Turkish Welfare Regime in Transition," *European Journal of Social Policy* 16, no. 3 (August 2006): 211-228. https://doi.org/10.1177/0958928706065593.

101 Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey," *Middle East Law and Governance* 2, no. 2 (January 2010): 171, https://doi.org/10.1163/187633710X500739.

Table 2.1 Indicators on health expenditures, 1999-2016

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total health expenditure (Million TL)	4 985	8 248	12 396	18 774	24 279	30 021	35 359	44 069	50 904	57 740	57 911	61 678	68 607	74 189	84 390	94 750	104 568	119 756
Proportion of total health expenditure to gross domestic product (%) [1]	4.7	4.8	5.1	5.2	5.2	5.2	5.2	5.6	5.8	5.8	5.8	5.3	4.9	4.7	4.7	4.6	4.5	4.6

(1) Related Indicator for 1999-2015 period has been revised due to the update of gross domestic product.

SOURCE TurkStat, Health Expenditure Statistics

Others suggest that the dynamics of marketization increase inequalities in access to health care services,[102] and some even suggest that occupational - and status - based inequalities in the pre-reform system have been replaced with income-based inequalities:

> Such inequalities are effects of the introduction of contributory payments for medications and hospital visits in both public and private hospitals , the introduction of additional payments for private hospital visits the establishment of the link between the quality of the health care services and levels of contributory and additional payments, and the definition of basic benefit package for public health insurance alongside the introduction supplementary private health insurance.[103]

The political dimension of health reform is also mentioned in the literature. Eder, for example, argues that the welfare regime transformation that includes the reform of health extended state power and created space for political arbitrage and clientelism. According to her, this politicization "can also explain why there has not been any significant political opposition to the welfare reforms in the country"[104] Buğra and Candaş also reflect on the political dynamics of welfare reform. They suggest that the reform pits a formally- employed minority whose rights are being eroded by ongoing neoliberal policies against an excluded group that it continues to support through assistance in kind, charity, and clientelism.[105]

This dissertation contributes to these analyses of the political dimension of welfare reform by demonstrating how AKP discourse on health reform depended on pitting two groups - health providers and receivers - against each

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102 Tuba Ağartan, "Marketization and Universalism or Crafting the Right Balance in the Turkish Health Care System," *Current Sociology* 60 no. 4 (2012): 456-471.

103 Volkan Yılmaz, "Changing Origins of Inequalities in Access to Healthcare Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey* 48 (March 2013): 73-74.

104 Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey," *Middle East Law and Governance* 2, no. 2 (January 2010): 182, https://doi.org/10.1163/187633710X500739.

105 Ayşe Buğra and Ayşen Candaş "Change and Continuity under an Eclectic Social Security Regime: The Case of Turkey," *Middle Eastern Studies* 47, no. 3 (May 2011): 526, https://doi.org/10.1080/00263206.2011.565145.

other. It does so by tracing how the two reform trends identified in the literature on Turkish health reform - universalism and marketization - were taken up and used in the political discourse and debate on the health reform.

The chapters 3, 4, and 5 will demonstrate how the AKP along with the pro-government media foregrounded one of these trends in health reform –universalism - in building its discourse on health reform and larger populist politics. The chapters 6, 7 and 8 will show how contesting actors led by the TTB emphasized the second trend in health reform – marketization - in formulating their anti-reform discourse.

3

AKP's Promotion of the Health Reform: The Discourse of a "Revolution in Health"

> *We have made a revolution in the health sector in every sense. We abolished the unhealthy bureaucracy that was causing our citizens to lose their health. We ended the differences among SSK, Bağ Kur and Emekli Sandığı, all the health institutions are under the same roof now. No more citizens are rejected from hospitals or detained in hospitals. We broadened the coverage of the Green Card as well.*[1]

This was the statement of then Prime Minister Recep Tayyip Erdoğan during a speech delivered in Iğdır before the 2011 parliamentary elections.

This chapter will examine how the "revolution in health" discourse of the AKP government - which builds on the arguments of a "human centered mentality," the promise of equality not enjoyed in pre-AKP periods, and an image of a government that sides with the people - was constructed around specific issues regarding health care.

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1 "Sağlıkta Adeta Devrim Yaptık," *Türkiye Bülteni* 70: (May-June 2011), 9, http://www.turkiyebulteni.org/PDF/70%20TB%20MAYIS%20HAZIRAN.pdf. (See appendix C.1 for the original.)

These specific issues will be discussed in two subsections and based on an analysis of the AKP election bulletins of 2002, 2007, and 2011; the 58th, 59th, 60th, and 61st government programs; speeches of and interviews with the minister of health and other members of the government on health policies as reported in newspapers;[2] publications of the Ministry of Health between 2003 and 2011 on the progress of the health transformation program; the official monthly publication of the AKP, *Türkiye Bülteni;* and parliamentary debates during the passage of laws regarding general health insurance, full-time employment, and compulsory service.

The chapter will demonstrate how the government presents itself as determined to end deficiencies and victimizations in the health sector that it claims were caused by the previous system. The first subsection will concern cases of the patients detained in hospitals, and the second will concern how geographic and social-security based inequalities are claimed to be overcome by the AKP government.

As discussed in the introduction, in the AKP's populist discourse the central themes that emerged were serving the people, treating all citizens as equal, being just, representing a radically different approach from previous governments, and the claim to introduce a total change to the mentality of the country. This chapter demonstrates how health-care emerged as a key discursive space wherein the AKP's populist claims to end old Turkey's social inequalities and victimizations materialized. In other words, the chapter will tackle how policy and institutional changes listed in the Emergency Action Plan and partially undertaken during the 2002-2011 (which were outlined in chapter 2) were accompanied and supported by a coherent narrative in which the AKP adapted its broader discourse of "transforming old Turkey" and "bringing equality to the country" to the domain of health care.

As the chapter will demonstrate, the AKP's pro-reform discourse presents health care providers and health care receivers as opposing groups and positions the AKP as the protector of health care receivers who did not receive the services they deserved in the pre-AKP period. This discourse claims that

2 Mainly the news articles from the pro-government newspapers Zaman and Yeni Şafak are used in this section as the interviews with the minister of health or the speeches of the members of the government were given a wider coverage in them.

health care receivers were deprived of services they deserved mainly because health care providers (who are equated with doctors), like the country's other elites, prioritized their own interests rather than serving the people.

A frequent theme is that the AKP government has a radically different mentality from its predecessors and employs "a human-centered approach." The claim to prioritize serving the people over the working conditions and incomes of health-care providers is presented as a proof of this "human-centered approach." All these themes constitute the basis of the AKP's discourse of a "revolution in health."

It is frequently stated that the AKP government protects the rights of the people in general and of patients in particular from health care service providers such as doctors and hospital administrators. The latter-it is claimed-have a mentality of blocking patients from receiving health services. The AKP is presented as determined to end this mentality. "A change of mentality" is used to describe the starting point of the change to the health care sector from a "provider- oriented" to a "human-oriented" one.

Especially in its first years, the discourse of the AKP government's discourse on health exclusively emphasized its determination to resolve problems that were inherent to pre-AKP governments. In other words, "doing away with the previous health system's deficiencies" emerged as a central theme.

In this discourse, two specific issues are foregrounded as examples of the problems in the previous health system: patients being detained in hospitals after their treatment due to debt, and geographic - and social security - based inequalities in the health system.

The remaining part of this chapter will examine how the AKP built its populist, pro health reform discourse in relation to these specific issues. As the discussion will highlight, health care providers and receivers were constructed as opposing groups in the presentation of these two specific issues.

More specifically, the phenomenon of patients being detained in hospitals emerged as a concrete example of the claim to end "old Turkey's" victimizations in the AKP's populist discourse. Furthermore, the government used individual cases of patients detained in hospitals to construct a broader discourse in which the AKP is presented as protecting health care receivers from health care providers. The end of this practice is highlighted as an indicator of

how the AKP government protected the rights of the people in general and patients in particular from service providers – that is from hospital administrators, and doctors.

Similarly, changes to replace the geographic and social security-based inequalities in the health system are presented as a way of bringing an end to inequalities that it claims belonged to the "old Turkey." The introduction of general health insurance and the unification of public hospitals were presented within this discourse on equality.

§ 3.1 Claiming to Put an End to People's "Victimization": The Discourse on Patients Detained in Hospitals

> *The practice of being detained in hospitals is over. If I receive a denunciation about this the first thing I will do is detaining that doctor, detaining that mentality. Because I believe that this practice is imposed on our doctors by a wrong mentality. From now on no doctor will resort to such a solution. By preventing this, we are making a step to protect our doctors from contradicting their Hippocratic oath.*[3]

The practice of detaining patients became a news item during the 1990s especially on prime-time television news as well as in newspapers.[4] Following the end of their treatment, if a patient was not covered by a social security scheme and if they could not pay the amount billed to them the administrator of the hospital resorted to not allowing their discharge. This practice was named in news articles or news bulletins as being "detained" or being held "captive."

As a concrete case with an easily transmitted message, the issue of patients being detained was central both to the AKP's discourse and to the policy and

3 Statement by Recep Tayyip Erdoğan during the opening ceremony of Ümraniye State Hospital. "Hastanede rehin Devri Bitti," *Yeni Şafak,* March 17, 2004. (See appendix C.2 for the original.)

4 There is no exact or approximate number of the patients that had been detained in the hospitals in the pre-HTP period.

institutional changes it undertook in health-care starting early in the term of the first AKP government. The issue of detained patients continued to be brought forward on almost all occasions where the achievements of the government in the health sector are mentioned as a symbol of the AKP saving victimized citizens.

As the analysis presented in this chapter will show, the government used individual cases of patients detained in hospitals to construct a broader discourse in which the AKP was presented as protecting health care receivers from health care providers. The ending of this practice is highlighted as an indicator of how the rights of the people in general and of the patients in particular are protected from the service providers by the AKP government, and thus from the hospital administrators, doctors, and a mentality that allowed providers to persist with this practice.

The first circular published by the Ministry of Health of the 58th Government on 26th November 2002 was on the discharge of patients. In this circular, which was sent to the governor of all provinces in Turkey, Recep Akdağ requested that "in no health institutions should patients, mothers, or babies be detained on the basis of non-payment of hospital expenses."[5] In the same circular Recep Akdağ stated that:

"Necessary legal procedures will be taken against administrators who act in violation of this with the authorization granted to the ministry by relevant legislation."[6]

This practice symbolized the situation of patients who could not benefit from health services due to their financial status. The health care provider and health care receiver split is underscored in the discourses of AKP members of

5 "Sağlık Bakanı Recep Akdağ, ilk genelgesinde sağlık kuruluşlarından hastane masrafları ödenmediği gerekçesiyle hastaların, bebek ve annelerin rehin tutulmamasını istedi." "Hastalar Rehin Tutulmayacak," NTV, November 27, 2002, http://arsiv.ntv.com.tr/news/189894.asp.

6 "Sağlık Bakanı Recep Akdağ, aksine hareket eden kurum yöneticileri ve sorumluları hakkında ilgili mevzuat uyarınca bakanlığımıza tanınan yetkiler çerçevesinde gerekli kanuni işlemlerin yapılacağını duyurdu." "Hastalar Rehin Tutulmayacak," NTV, 27 November 2002, http://arsiv.ntv.com.tr/news/189894.asp.; "Taburcu İşlemleri Hakkında Genelge," İstanbul İl Sağlık Müdürlüğü, (Circular on the discharge of the patients), http://www.istanbulsaglik.gov.tr/w/mev/mev_gen/tedavi_hiz/taburcu_islemleri_Hakkinda_Genelge.pdf.

the parliament, the minister of health at the time, Recep Akdağ, and the prime minister, Recep Tayyip Erdoğan. The discourse referring to the problem of detained patients pits health care receivers against health care providers, especially hospital administrators and doctors.

During a speech delivered in parliament on the occasion of Doctors' Day (Tıp Bayramı) in 2007, AKP member of the parliament Osman Akman stated:

> We could not put into practice the law[7] that seeks to cover all poverty-stricken citizens who are not covered by any social security scheme due to the block of the Constitutional Court. Just recently, we learned from the press what one family faced because of the annulment of certain articles and of the postponement of its implementation. We witnessed a case that does not correspond with human moral and honor codes when a university hospital insisted on cashing the debt of a poor family. I leave it to our people's conscience to decide if there is any more proper occasion where a health institution administrator should take personal initiative. Prior to our administration, we frequently witnessed similar cases taking place in the hospitals of the Ministry of Health, but our government's stand is clear on this issue: "help the people survive so that the state survives."[8]

The case mentioned by the member of the parliament is of a family sentenced to prison for not being able to pay their debt to the University of Mersin Hospital for the birth of their son by cesarean section in 2004. They were discharged from the hospital after signing a bill of debt, and they were sentenced to ten days imprisonment in judicial proceedings when they were unable to pay part of that debt. After staying one night in the hospital with their two-

7 The law mentioned here is the GSS, no: 5510 General Health Insurance Law.

8 "Antalya Milletvekili Osman Akman'ın, 14 Mart Tıp Bayramı ve Sağlık Haftası'na, ülkemizde hekimlik mesleğinin tarihçesine, sağlık sisteminde karşılaşılan sorunlara ve alınması gereken tedbirlere ilişkin gündem dışı konuşması," (Speech Delivered by Antalya mp Osman Akman on Doctor's Day) TBMM Tutanak Dergisi, Cilt: 150, 75. Birleşim, 14 March 2007: 7, https://www.tbmm.gov.tr/tutanaklar/TUTANAK/TBMM/d22/c150/tbmm22150075.pdf. (See appendix C.7 for the original.)

year-old, they were released when a businessman paid their debt to the hospital. At the same time, Prime Minister Erdoğan stated that "for such a reason I would not allow even one of my citizens go to prison."[9]

In these statements of the member of the parliament and the prime minister, the health care provider and health care receiver split is made clear through pointing out the decision of the administrator of the hospital in question in this individual case. It also underscores President Ahmet Necdet Sezer's veto of certain articles of the law and the ensuing decision of the Constitutional Court to revoke Law 5510 on Social Insurance and General Health Insurance (5510 no'lu Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu), a motion that was filed in court by the CHP and Ahmet Necdet Sezer[10] to prevent citizens from receiving health services regardless of their financial status. Even though the case was used as an example in the discourse, it is not exactly a case of a patient being detained in a hospital for the inability to pay. As it unfolded it was a similar situation, as it resulted - not in detainment in the hospital - but in a prison sentence. The problems arising from patients' debts to hospitals and its consequences was thus a significant symbol of the AKP government's determination to end victimizations. Hence, it was no coincidence that the first circular of the Ministry of Health in 2002 was about patients detained in hospitals.

An article entitled "Order from the Minister of Health to Chief Physicians" (*Sağlık bakanından başhekimlere talimat: Hastaları rehin almayın*) is about the declaration by Minister of Health Recep Akdağ in the Ministry of Health's first circular. The circular states that no patient should be detained in a hospital after their treatment is complete for not having paid their bill. The same circular also stated that all private and public hospitals must provide emergency

9 "Böyle bir şeyden dolayı bir tane vatandaşımı hapse sokturmam." "Hastane borcu nedeniyle hapse Sağlık Bakanlığı'ndan inceleme," *Zaman*, March 7, 2007, http://www.zaman.com.tr/_hastane-borcu-nedeniyle-hapse-saglik-bakanligindan-inceleme_510041.html.

10 "Press Release by the Presidency on the veto of the law number 5489" https://www.tccb.gov.tr/basin-aciklamalari-ahmet-necdet-sezer/1720/6983/5489-sayili-kanun.html. "The decision of the Constitutional Court on the Law no 5510" *T.C Resmi Gazete,* no: 26392, December 30, 2006. http://www.resmigazete.gov.tr/eskiler/2006/12/20061230m5.htm.

services twenty-four hours a day.[11] Here the ministry makes it clear that the foremost priority is to ensure that all citizens are equally treated; ending the practice of detaining patients in hospitals was their first step towards this promised equality. In doing so, the ministry makes clear that the AKP government's utmost priority is to serve all citizens in need regardless of their social security coverage or ability to pay.

The position of the ministry on the practice of detaining patients was frequently underscored by both Minister Akdağ and Recep Tayyip Erdoğan. In some cases, like the one mentioned above, their declarations were general in nature. In other cases, on the other hand, they concerned a specific, detained patient and how the ministry followed up the case. In an article entitled "Nobody Will Be Detained in the Hospitals Anymore" *(Artık Kimse Hastanede Rehin Kalmayacak),* the general position of the government on this practice is declared by Akdağ in a different manner. Akdağ differentiates the position of the AKP from previous governments, stating:[12]

> I am making it clear once more: no patient will be detained in hospitals anymore. It is a thing of the past. We have to be clear that there is no justification for holding a patient in a hospital; it is a habit more royalist than the king. It is an issue that disturbs the conscience of the people, and we do not want such a thing to happen in any hospital anymore.[13]

In an article in the daily *Zaman* entitled "Investigation Started for the Detained Baby" *(Rehin Bebek için Soruşturma Başlatıldı),* the minister's approach towards a specific case of a baby being detained in a hospital in Eskişehir is described. Recep Akdağ states that "Our colleagues are following this case; the baby will soon be returned to his family and those who caused this situation

11 "Sağlık bakanından başhekimlere talimat: Hastaları rehin almayın." *Zaman*, November 28, 2002, http://arsiv.zaman.com.tr//2002/11/28/haberler/h2.htm.

12 "Artık kimse hastanede rehin kalmayacak," *Zaman*, December 6, 2002. http://arsiv.zaman.com.tr//2002/12/06/doguanadolu/h5.htm.

13 "Artık kimse hastanede rehin kalmayacak," *Zaman*, December 6, 2002. http://arsiv.zaman.com.tr//2002/12/06/doguanadolu/h5.htm. (See appendix C.8 for the original.)

will be investigated."[14] The emphasis of the ministry and the government on the fact that they protect the rights of health care receivers is underscored here by assuring that health care providers will be punished and by following up on every case that reaches them.

This theme emphasizing the determination of the government to end victimizations can be observed in the discourses of the then Prime Minister Recep Tayyip Erdoğan, as well. In a speech delivered on 17 March 2004, Erdoğan stated that

> the practice of being detained in hospitals is over. If I receive a denunciation about this the first thing I will do is detaining that doctor, detaining that mentality. Because I believe that this practice is imposed on our doctors by a wrong mentality. From now on no doctor will resort to such a solution. By preventing this, we are making a step to protect our doctors from contradicting their Hippocratic oath.[15]

These statements of the government underscore its determination and its intolerance of the practice of detaining patients in hospitals. This emphasis can be observed in a statement of Recep Akdağ:

> There has been no case of a detained patient for a few weeks thanks to precautions have taken. And as the press is also following the matter closely over the last few weeks, no patient has been detained in a hospital for not having enough money to pay. For those who act to the contrary, we will take necessary actions.[16]

The ministry is portrayed as an actor that not only bans the practice but which follows up on its decision and punishes those who act to the contrary.

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14 "Arkadaşlarımız konuyu yakın takibe aldılar. Bebek en yakın zamanda ailesine teslim edilecek. Bu konuda ihmali olanlar hakkında soruşturma açılacaktır." "Rehin Bebek için Soruşturma Başlatıldı." *Zaman,* December 15, 2002, http://arsiv.zaman.com.tr//2002/12/15/haberler/h13.htm.

15 "Hastanede rehin Devri Bitti," *Yeni Şafak,* March 17, 2004. (See appendix C.2 for the original.)

16 "Sağlık Bakanı Recep Akdağ: Hastanelerdeki rehin olayı bitti," *Zaman*, February 3, 2003, http://arsiv.zaman.com.tr//2003/02/03/haberler/h12.htm. (See appendix C.8 for the original.)

Reform of the health system is an issue that is frequently brought up by the AKP during electoral campaigns where bringing an end to the victimizations of the people is presented as among the most important achievements of AKP governments. The issue of detained patients in hospitals is a concrete example of the claim to end these victimizations. In the electoral bulletin of the AKP for the June 2011 elections, the issue of patients detained in hospitals is mentioned as an achievement of the three governments formed by AKP in 2002, 2003, and 2007. The 2011 election bulletin of the AKP mentions that

> we provided a human-focused service with the principle of "Loving the created for the creator's sake." Thus, we acted with the approach of "serving the people" which is at the core of the politics of the AKP. Our responsibility is not to some other centers but only to our people.[17]

Following this introduction, the first achievement brought up in the bulletin is the end to the practice of detaining patients in hospitals: "The health sector is no longer a sector of ordeal; the period when a patient without money is detained in a hospital is now history, a 'revolution in health' that aims to protect the poor is being made."[18]

In an issue of *Türkiye Bülteni*[19] published a month before the 2011 elections, the end of the detention practice is mentioned as a part of the "revolution in health" by Recep Tayyip Erdoğan at a rally in Iğdır:

> We have made a revolution in the health sector in every sense. We abolished the unhealthy bureaucracy that was causing our citizens to lose their health. We ended the differences among SSK, Bağ Kur and Emekli Sandığı, all the health institutions are under the same roof now.

17 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 82, www.akparti.org. (See appendix C.151 for the original.)

18 "Sağlık sektörü çile sektörü olmaktan çıkarıldı. Parası olmayanların hastanelerde rehin alındığı dönemler tarihe karıştı.Fakir fukarayı görüp gözeten bir sağlık devrimi yapıldı." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 82, www.akparti.org.

19 Türkiye Bülteni is the official monthly periodical of AKP which in some periods has been published bimonthly. The periodical consists of interviews with ministers, activities of the government and news about meetings organized by AKP.

> No more citizens are rejected from hospitals or detained in hospitals, and we broadened the coverage of the Green Card as well.[20]

Thus, the issue of detained patients is counted among the major achievements of the government and is part of what is called a "revolution" in the health sector. In other words, it is an indicator of the changed mentality in the health sector. To illustrate, in an issue of *Türkiye Bülteni* published prior to the 22th July 2007 parliamentary elections, the first achievement mentioned is detained patients:

> The starting principle for the AKP government on the health issue was 'no citizen will be deprived of health services.' Firstly, the practice of detaining patients in hospitals has been stopped. In emergency admissions to hospitals, the practice of rejecting patients and demanding ambulance payments has been abolished.[21]

The practice of detaining patients unable to pay their bill following treatment is portrayed as the weakness of previous governments with respect to protecting citizens from health care providers. In other words, it is frequently underscored that for the first time a government was siding with health care receivers. Hence, bringing an end to this practice was not only mentioned early in the rule of the AKP but continues to be mentioned in various mediums as a significant achievement of the government.

As this section demonstrates, the AKP's discourse on detained patients presents health care providers as the main obstacle to citizens receiving health care. This representation fits with the AKP's broader populist discourse of an "old Turkey" where elites ruled and the rights of citizens were limited as a consequence of deep-seated privileges and habits that resulted from a political culture that favored elites. In the case of the health sector, doctors were portrayed as those elites.

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20 "Sağlıkta Adeta Devrim Yaptık," *Türkiye Bülteni* 70: (May-June 2011), 9, http://www.turkiyebulteni.org/PDF/70%20TB%20MAYIS%20HAZIRAN.pdf. (See appendix C.6 for the original.)

21 "AK İktidarın 4 Yıllık Sağlık Karnesi: Sağlıkta Dönüşüm Yılları," *Türkiye Bülteni* 47 (April 2007): 48. http://www.turkiyebulteni.org/PDF/47%20NISAN%202007.pdf. (See appendix C.10 for the original.)

§ 3.2 Claiming to Bring About Equality

AKP delineates itself from contemporary political actors and predecessors by emphasizing its "passion" and "commitment to serve the people" who have not treated in the way they deserved. In this subsection, the discussion will be on how the AKP presents health reforms as a way to eliminate inequalities that were deeply rooted until their arrival in power. These inequalities stemmed either from the fractured social security system or from geographic disparities and took the form of unequal distribution of health facilities and personnel.

3.2.1 *Claiming to end geographic disparities*

During an interview in which he was asked what the core of the health service policy of AKP was, Recep Akdağ stated that:

> our departure point was "health for everyone" and we put 'human' at the center of our services. Those who have or don't have money, the educated and the uneducated, those who live in urban areas, those who live in rural areas - health is a right for all of them. We built our ambitions to make it possible for all citizens to easily reach services and receive high-quality services. We built the health transformation program on this basis. Our moral understanding is a determining factor in every step we make. Just because they were living in rural areas, approximately 30% of Turkey's population had difficulty receiving health services. There were no roads to reach[the services], insufficient personnel and facilities when they were reached, and more importantly, there was no hope of these people to access health services.[22]

In the discourse of the AKP about health, as can be inferred from Akdağ's statement, equality means allowing rural people and people without social security coverage to access services. Additionally, as in the majority of their statements about the health sector, they summarize their departure point as placing the "human" at the center, which can be interpreted as protecting

22 "Sağlıkta Dünya Markası Olmayı Hedefliyoruz," *Türkiye Bülteni* 56 (July-August 2008): 27, (See appendix C.11 for the original.)

health care receivers from health care providers and prioritizing the people in the actions carried out in the health sector. The steps made in the initial years of AKP rule were to introduce measures to encourage doctors and health personnel to choose to work in previously unpopular regions.

During a parliamentary speech on the occasion of the 14 March Doctors' Day, AKP member of the parliament Beyribey stated that

> in Turkey there is a big imbalance in personnel distribution between east and west, provincial centers and districts and villages. There is progress on this, but I do not think that it is sufficient. In many regions we still experience a scarcity of doctors and health personnel. We tried to resolve it with contractual status employment, but I don't believe that it was sufficient. I strongly believe there should be further improvements made - maybe via increasing the pay of doctors who are contractually employed, maybe through revolving funds or funds from other sources – so that pay for the least preferred regions can be increased.[23]

In addition to emphasizing overcoming inequalities resulting from a lack of personnel in certain regions, emphasis on how rural-urban disparity was being dealt with by the AKP government is another issue that appeared in election bulletins. The 2007 election bulletin stated that the 112 emergency service would be provided not only in urban areas but also in rural areas and that in rural areas, citizens would be reached with mobile health care service units.[24]

Geographic inequality is an issue that emerges frequently in the discourses of the AKP. In early years, AKP government discourses about geographic inequality focused on the lack of services provided to rural areas and how the "new government" was determined to abolish these inequalities. As emerged in earlier examples in this chapter and as will be shown in chapter 5, the provider-receiver split is present in rural-urban disparity discourses. During a

23 "Kars Milletvekili Yusuf Selahattin Beyribey'İn Tıp Bayramı'na ilişkin konuşması," TBMM Tutanak Dergisi, Cilt:150, 70. Birleşim, March 15, 2005, https://www.tbmm.gov.tr/tutanak/donem22/yil3/bas/b070m.htm. (See appendix C.12 for the original.)

24 "AKP 2007 Seçim Beyannamesi," June 2007, 81, www.akparti.org.

visit to the provincial director of health, the president of the AKP in Bursa province stated:

> In village health units there is a scarcity of midwives. Those that are appointed there do not want to go to the villages. We will ask the districts to provide nurses and midwives to villages through payments via revolving funds.[25]

The lack of health personnel in eastern provinces is an issue mentioned in terms of geographic inequality. As in the previous example, the choice of people in the health sector – midwives and nurses but especially doctors - not working in certain regions is shown as the root of this inequality. As in other examples presented in this subsection, the statements of government officials underscore the determination of the government to bring an end to this inequality and the difficulties experienced by placing the provider-receiver split in the background. The government is positioned as an actor that decidedly secures the presence of doctors in the eastern provinces through changes to policies and specific measures. A speech delivered by Recep Akdağ in 2004 exemplifies this position of the government:

> I worked in Erzurum for 20 years as a doctor, and as long as I can remember there is a scarcity of health personnel in eastern and southeastern provinces. This is an unacceptable situation for Turkey in 2004. In places that experience recruitment problems, we tried to resolve it by appointing contractual personnel. In one year, we sent 13 thousand personnel to the region, which is a record number in the last 20 years. So the problem of auxiliary health personnel was resolved. However, there is still a scarcity of specialist doctors. For specialist doctors, we proposed a [monthly] salary of 3 billion Turkish lire and a bonus of 500 million Turkish lire.[26] Together with the revolving funds, a specialist doctor has the chance to earn up to 8 billion Turkish lire, but they

25 "Tunçak: Sağlık Sorununu Çözeceğiz," *Zaman*, January 17, 2003, (See appendix C.152 for the original.)

26 By 1st of January 2005 6 zeroes has been deleted from the Turkish Lira and the currency in five years time was renamed as the New Turkish Lira.

> do not want to go. In the Law for the Contractual Personnel we are working to further increase the incentives. If despite all this we still cannot fill the deficit of specialist personnel, we will implement an obligatory, long-term rotation for specialist doctors working in the public sector. District governors, solicitors, and soldiers work everywhere, and I believe doctors would also accept to work equally.[27]

The early statements of the minister and AKP officials strongly stressed issues that create inequality in the health system and their insistence in overcoming these inequality - generating practices. Recep Akdağ's statement points out the roots of the lack of health personnel in eastern and southeastern provinces, and he declares that this problem will be resolved by implementing new policies. Furthermore, doctors are portrayed as a professional group that distinguish themselves from other public servants. By the change of policy, the minister is in one way promising equality among public servants, which according to his claim would abolish previously-enjoyed privileges of doctors compared to other public officers.

Statements in later years emphasize what was accomplished since the first AKP government. The differences in practices and the provision of equipment is highlighted. Such before – and - after comparisons are clearly observed in election bulletins. The issue of inequality between rural and urban areas in terms of ambulance service was identified in the 2011 election bulletin exemplifies such a comparison:

> Before our government, citizens had to pay for ambulances to carry patients. There was no ambulance service in our villages. Now we provide ambulance service in our villages and even, when needed provide totally free service with our twenty air ambulances.[28]

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27 "Doktorlar Doğu'ya Zorunlu Gönderilecek," *Zaman,* April 25, 2004, http://www.zaman.com.tr/gundem_doktorlar-dogu-ya-zorunlu-gonderilecek_40861.html. (See appendix C.13 for the original.)

28 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 84, www.akparti.org. (See appendix C.32 for the original.)

Emergency service units (112 emergency stations) are mentioned both in terms of both their increasing number over the years since the AKP government came to power and the equality of their distribution between urban and rural areas. An issue of *Türkiye Bülteni* published A few months before the 2007 parliamentary elections states that "three times more people made use of 112 emergency stations, an issue prioritized by the AKP government, and at the same time, 95 percent of the rural population can [now] take advantage of this service."[29]

In the 2007 election bulletin of the AKP, the claim of overcoming disparity among regions is emphasized in the framework of the government's prioritization of the health sector as well as how the problems of people stemming from this disparity was brought under control.

> We prioritized regions that lacked buildings, equipment, and health personnel and abolished the imbalanced situation to a large extent. We have recruited almost 100,000 health personnel in the public sector. In a period of limited recruitment in the public sector, we hired the majority for the health sector and resolved a problem that created complaints from our people about the lack of health personnel. By bringing together sufficient buildings and equipment, we have developed the quality and scale of services all around the country.[30]

3.2.2 *Claiming to End Inequalities Stemming from the Fractured Social Security System*

Starting in the early years of AKP governance, the general health insurance system was presented as a project to end the extant inequalities that derived from the fragmented social security scheme. Before the law concerning the

29 "AK PARTi iktidarının özel önem verdiği 112 acil istasyonu ve bu hizmetten faydalanan kişi sayısında 3 kata yakın artış sağlanırken, kırsal kesimin yüzde 95'i bu imkandanyararlanır hale geldi." "AK İktidarın 4 Yıllık Sağlık Karnesi: Sağlıkta Dönüşüm Yılları," *Türkiye Bülteni,* 47 (April 2007): 49, http://www.turkiyebulteni.org/PDF/47%20NISAN%202007.pdf.

30 "AKP 2007 Seçim Beyannamesi," June 2007, 79, www.akparti.org. (See appendix C.14 for the original.)

general health insurance system was prepared and passed, citizens were allowed in practice to use health facilities that they had not been able to use until then as a consequence of the given social security system to which they belonged. These practices were introduced as steps towards establishing equality among citizens. As election bulletins are designed to persuade voters, completed tasks as well as promises make up an important part of these documents. Before the 2007 and 2011 elections, the Health Transformation Program and the practices of the government in the health sector occupied a significant place. The common theme in both campaigns concerning the health sector was that "up-until-then" ignored people started to receive health services as equals.

The section devoted to health in the 2007 election bulletin compiles the achievements of the government during the 2002-2007 period and points to overcoming inequalities.

> As we think health services are a basic right, we let the people access it without any discrimination. All our citizens can go to any hospital they want including university hospitals and private ones. The rights of citizens with a Green Card have been broadened as their ambulatory care and pharmaceutical expenses are now covered by the state. People with SSK coverage can obtain their medicine from pharmacies with a contract with the state, so millions of people do not have to suffer in queues to buy medicine. We have provided them with the quality services they deserve.[31]

These achievements point to steps made by the AKP government designed to render equal citizenship status to all citizens while at the same time underscoring the situation that existed before the AKP government and emphasizing how the new practices are saving people from being victims.

Cevdet Erdöl, the Grand National Assembly of Turkey (Türkiye Büyük Millet Meclisi or TBMM) Health, Family and Social Work commission chair,

31 "AKP 2007 Seçim Beyannamesi," June 2007, 77. www.akparti.org. (See appendix C.15 for the original.)

was interviewed about the passage of the law[32] that transferred all health units belonging to public institutions together with the responsibilities, rights, and liabilities related to them to the Ministry of Health. When asked what changes this transfer would bring about for patients Erdöl stated that:

> You are an employee in an insurance institution and cannot get examined by a doctor other than the one to which the insurance company directs you. You cannot go to a hospital other than the one to which the insurance institution directs. You cannot buy medicine from a pharmacy other than its own pharmacy the one to which it directs you. You are in fact placed in a mould, and we are breaking this mould - breaking it for the benefit of the patient. With the common usage protocol,[33] the large part of it has already been broken. After this practice patients with SSK coverage - our worker brethren - when they went to public hospitals, did they feel uncomfortable? No. On the contrary patients, with SSK coverage felt very much relieved. They went to whichever community clinic or public hospital they wanted. Our state officers, too, could go to any SSK hospital they wanted. This practice was also a step towards the liberty of choosing your doctor. Imagine you are a worker from the Haymana district of Ankara or a relative of this worker. Let's assume that there is a community clinic close to your house. You cannot make use of this community clinic. You are also a citizen of this country, you are also covered by social security, so why can't you make use of this service? This should be your natural right. We, the AKP government, brought this right to you. Everyone with health insurance is enjoying the comfort of going to whatever hospital or community clinic they want to. The biggest aim in uniting the hospitals under one roof is, after all, to provide good service to patients.[34]

32 "Bazı Kamu Kurum ve kuruluşlarına ait Sağlık Birimlerinin Sağlık Bakanlığı'na Devredilmesine Dair Kanun no. 5283," http://www.mevzuat.gov.tr/MevzuatMetin/1.5.5283.pdf.

33 "Ortak Kullanım Protokolü," http://www.resmigazete.gov.tr/eskiler/2014/05/20140503-3.htm.

34 *Türkiye Bülteni* 21 (February 2005): 29. (See appendix C.16 for the original.)

On the same issue, Recep Akdağ, the Minister of Health, stated in an interview about the transfer of SSK hospitals to the ministry that:

> With this practice which will enable all our citizens to easily access the health service they deserve without being exposed to any discrimination, efficiency will be increased, and the way towards providing everyone equal, fair, fast, and efficient health services will be paved.[35]

The transfer of SSK and the hospitals of other institutions to the ministry is presented as a move that equalizes all citizens as they are able to receive services from health units without being limited by the social security scheme under which they are covered. This issue is presented as a right provided mainly to citizens with SSK coverage of which had been deprived. It is placed in the broader discursive framework of the AKP eliminating the unjust treatment to the people, bringing an end to the privileges of a certain part of the population, positioning themselves as closer to people, and saving them from the injustices that they endured before their governance.

During the 2011 election campaign, the slogan "Durmak yok yola devam!" the emphasized the equality brought about by the AKP government in health services. Among the aims of the AKP for 2023 was:

"Regardless of their financial status and without discriminating among our people, we will continue to consider all of them as first-class citizens of the country."[36]

Regarding the services the AKP government had provided by 2011, the emphasis was on the increase of equality, and the possibility for people with SSK coverage to use hospitals other than those in the SSK network was underscored.

> 37 million workers, their families, and pensioners were bound to 370 hospitals and dispensaries. We united the hospitals under one roof. We made it possible for our citizens to receive services from all hospitals

35 *Türkiye Bülteni* 22(February 2005): 22. (See appendix C.17 for the original.)

36 "Maddi durumu ne olursa olsun insanımızı birbirinden ayırmadan, ülkemizin birinci sınıf vatandaşı olarak görmeye devam edeceğiz." AKP Election Bulletin 2011, 85.

> with their existing social security. These 37 million people can now, like all other citizens, get services from 2330 hospitals and medical centers and 6336 family health centers.[37]

The number of hospitals that citizens with SSK coverage were able to use before the "ortak kullanım protokolü" (common usage protocol) and the transfer of SSK hospitals to the ministry was stressed; thus the equalizing impact of the AKP government is underscored. During the opening ceremony of "Acil ve Afetlerde Sağlık Hizmetleri" (health services in emergencies and disasters) Recep Tayyip Erdoğan mentioned that "we made it possible for more than 30 million citizens covered by SSK who were trying to receive services from 150 hospitals to make use of all public health units."[38]

The emphasis on ending the difficulties of people covered by SSK was also frequently mentioned during election speeches delivered by Erdoğan before the 2011 parliamentary elections. It should be noted that even when delivered in different provinces, those speeches have a similar structure. Erdoğan speaks about the achievements of AKP governments in general and what has been done by the AKP for that province in particular. On health, two main issues are highlighted. Firstly, the number of equipment and number of ambulances, specialist doctors, midwives, and nurses before and after the AKP government are stated. The second major issue that is brought up is the outcomes of general health insurance and the transfer of SSK hospitals to the Ministry of Health for citizens in general and for citizens covered by SSK in particular. The conditions that were present in SSK hospitals before their transfer to the Ministry of Health in terms of the services people received was strongly emphasized.

Erdoğan positions his party in opposition to what precedes the AKP governments in terms of approaching the people and prioritizing the human, as mentioned beforehand. While doing this he equates pre-AKP practices among

37 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org. (See appendix C.18 for the original.)

38 "150 hastaneden hizmet almaya çalışan 30 milyondan fazla SSK'lıya, kamuya ait tüm sağlık sistemlerinden faydalanma imkanı getirdik." "Sağlık için Dev Adımlar" *Türkiye Bülteni,* 54 (March-April 2008): 31.

health care providers and the main opposition party and its leader, Kemal Kılıçdaroğlu, who was the former director general of the SSK.

During a rally in Artvin Recep Tayyip Erdoğan stated that:

> I would like to remind you that during the 90's the director general of the SSK was Mr. Kemal. The ordeals you experienced are because of him. In the surgery rooms of SSK hospitals, wedges were used to hold the bed in place. Now, in Van, the beds in the surgery rooms turn with a remote control. There were no proper lighting systems in the surgery rooms. These conditions all belong to a time when Mr. Kemal was administering the SSK. Money is of no importance; what matters for us is public health. Now, just by showing an ID, everyone can enjoy health services. But the CHP opposed these changes.[39]

During these speeches, Recep Tayyip Erdoğan also mentioned how the people under SSK coverage experienced difficulties stemming from the practices embraced by the health care providers, again underlining the role of Kemal Kılıçdaroğlu in the SSK. During a speech delivered in Kazlıçeşme, İstanbul, he stated:

> Before our arrival, he was the general director of SSK for eight years. The dead and the living remained captive in hospitals. I was a worker, too; we suffered a lot. The doctor used to ask us to come to his private clinic to provide proper treatment. Then he used to give us a prescription, but half of the medications he prescribed could not be found in pharmacies. Please tell this to my brothers who vote for the CHP. I am not asking you to convince them, I just ask you to tell them. I am sure there will be ones among them who will understand.[40]

Here, doctors are portrayed as unwilling to provide services to health care receivers in hospitals but do so on the condition of receiving them in their private clinics - in other words, only for extra payment. As discussed earlier, the

39 "Başbakan Recep Tayyip Erdoğan Hopa Mitingi 31.05.2011" Posted anonymously, October 2, 2011, video, 40:31. https://www.youtube.com/watch?v=ITPM8iEG1fg.

40 "Başbakan Recep Tayyip Erdoğan Kazlıçeşme Mitingi 5 Haziran 2011" Posted anonymously, October 2, 2011, video, 02.23.31. https://www.youtube.com/watch?v=llBDQvUnMOU.

governments that preceded AKP are equated with a mindset that does not prioritize the health of the people, and these predecessors are materialized in the personality of Kemal Kılıçdaroğlu. The way he describes doctors and Kılıçdaroğlu should be noted as it is also a point where the discourse of the AKP distinguishes itself from its predecessors.

During the speech he refers to Kemal Kılıçdaroğlu as "Bay Kemal" which translates into English as Mr. Kemal, but in Turkish the word "bay" has the same meaning but a different connotation from the more common word "bey" which has the same meaning. The former began to be used after the foundation of the republic, and it carries the connotation of republican elitism. As the former director general of SSK and the president of the main opposition party, Kemal Kılıçdaroğlu is thus made to stand for elites who are indifferent to the urgent, basic needs of the people. Recep Tayyip Erdoğan, during the same speech, calls doctors of whom he is critical "doktor efendi," a title that in contemporary Turkish is used mostly to refer to concierges or handymen. Thus, by referring to a doctor as efendi he "devalues" the status of doctors and strengthens his discourse that health care providers (who are educated elites) are no longer allowed to deprive citizens of the services they deserve.

The main emphasis with respect to the abolition of differences among different social security schemes is the improvement of the conditions of Green Card holders and citizens covered by SSK. The role of the AKP government is defined as being a determined actor able to overcome the inequality among people. Making it possible for people with SSK coverage to use hospitals other than SSK ones is underscored more so than the broadening of access or people covered under other schemes. This can be explained by the unarguably larger number of people under the SSK scheme. The distinguishing feature of the AKP government's presentation of itself is that it resolves problems that up until then were regarded as impossible to resolve, - deep-seated problems that citizens had experienced for a long time. During an interview conducted during the AKP government's first year, Recep Akdağ summarizes the steps made on the issue of the access of SSK covered citizens to health units other than SSK health institutions and why the same steps were not made by previous governments.

> Short-term governments, the existence of coalition governments, and as I mentioned earlier, a mentality that did not put humans at the center of their ambitions made it hard for them to realize the changes they were aiming for. The same is valid for the complicated health security systems in Turkey, too. For years in our country the use of hospitals belonging to the Ministry of Health by citizens covered by SSK was discussed, but no one was able to made the necessary steps to make it happen. We made these steps in a very short time. In three big provinces, our hospitals started to provide common services to our people. As you know, in September five other provinces were included in this practice. In the coming days, our hospitals and other health institutions will be able to serve all our people.[41]

During some speeches of the minister of health and prime minister, the overall equality granted by the common usage protocol is also mentioned. For instance, during the opening ceremony of one hospital, Recep Tayyip Erdoğan stated:

> By bringing together the public and private sector and foundations we made it possible for pensioners, workers, Green Card holders, and those with Bağ-Kur coverage to make use of all hospitals. To be able to realize this needed love and passion, and we do all these things with love and passion.[42]

Here it can be observed how the equality brought through policy changes is equated with loving the people and saving them from a confined, limited health system where they were not free to obtain services from any hospital they liked.

The introduction of General Health Insurance and the unification of the social security schemes are issues that are brought forward, as mentioned earlier, since the early days of the AKP rule. These issues are presented within the

41 *Türkiye Bülteni* 5 (October 2003): 41. (See appendix C.19 for the original.)

42 *Türkiye Bülteni* 48 (May 2007): 48. (See appendix C.20 for the original.)

framework of equalizing citizens by letting them receive equivalent health services. This concern is present in the government programs of the AKP since the first government formed in November 2002.

Following the establishment of the government, the prime minister presents these programs that summarize the plans of the government in various areas such as economics, education, national security, and health to parliament. Alongside the publications of the party and statements of government officials, these programs are significant in that they show which issues in health are prioritized and how they are presented and conveyed in the government's official agenda.

In the sections devoted to health in the four government programs are issues that are included in the Health Transformation Program. The issues of general health insurance and the common usage of hospitals by citizens belonging to different social security schemes are presented within the framework of equality.

In the government program of the 58th government that lasted for four months until March 2003, there is a short evaluation of the Turkish health sector wherein the sector is portrayed as being unable to meet the needs of all citizens. The necessary steps to change the health sector are defined in the following way:

> Our present health system is not able to meet needs given its institutional structure, functioning, employee structure and distribution. Unfortunately, only 81 percent of our citizens are covered by health insurance while 19 percent have no health insurance. The state has the obligation to provide basic health services for everyone - by collaborating with the private sector, if needed. And for quality health service, discrimination among state hospitals, insurance hospitals and institutional hospital will be abolished, and hospitals will have financial and administrative autonomy.[43]

43 "58. Hükümet Programı," 2003, https://www.tbmm.gov.tr/hukumetler/HP58.htm. (See appendix C.21 for the original.)

The emphasis in the quotation above is that the health system in its present form cannot be reached equally by all citizens and that the AKP government sees it as an obligation of the state to make health services accessible to everyone. The 59th government was formed 4 months after the first AKP Government following the election of Recep Tayyip Erdoğan to parliament, and his assumption of the post of prime minister. Thus, in terms of health, there is little difference between the two programs, but the equality issue is again underscored as seen in this statement of Recep Tayyip Erdoğan: "Our government is determined to constitute a high quality health system to which everyone can have access by making radical changes."[44] Thus, the main emphasis is on making the system accessible to all citizens regardless of their coverage.

Unlike the first two, equality in the 60th and the 61st government programs is presented through changes made to the health system by the AKPin the framework of the Health Transformation Program. In the 60th government program which was delivered by Recep Tayyip Erdoğan in July 2007, he first states that "many obstacles that complicate the access of our citizens to health services have been abolished with courage and determination, and the 'Health Transformation Program' is being carried out with success in order to improve the distorted, unjust health system."[45] He then clarifies how equal access to health services is provided, underscoring how following these adjustments there are no longer differences among citizens.

> Beginning with hospitals belonging to the SSK, all hospitals belonging to public institutions have been transferred to the Ministry of Health. Now, all our citizens can go to any hospital they choose including university and private hospitals, can get examined by any doctor they want, and can get their medications from any pharmacy they want. In

44 "Hükümetimiz, köklü değişiklikler yaparak herkesin ulaşabileceği nitelikli ve etkin çalışan bir sağlık sistemini oluşturmakta kararlıdır." "59. Hükumet Programı," 2003, https://www.tbmm.gov.tr/hukumetler/HP59.htm.

45 "Vatandaşlarımızın sağlık hizmetlerine ulaşmasını zorlaştıran birçok engel cesaretle ve kararlılıkla kaldırılmış, sağlıktaki çarpık, hakkaniyetten uzak sistemi iyileştirmek üzere, kapsamlı bir "Sağlıkta Dönüşüm Programı" başarıyla yürütülmüştür." "60. Hükumet Programı," 2007, https://www.tbmm.gov.tr/hukumetler/HP60.htm.

> this way, the discrimination faced by our citizens depending on their social security schemes - such as Emekli Sandığı, Bağ-Kur, and SSK - has been brought to an end.[46]

The common usage protocol and the transfer of the SSK and other institutional hospitals to the Ministry of Health are presented as important steps towards equalizing citizens. In the 61st government program presented to parliament in July 2011, the health issue comprises a larger part than in previous programs as the changes made by the government from 2002 onwards are mentioned. It should also be noted that during the 2011 election campaign, the Health Transformation Program in particular and the changes that took place in the health sector in general were underscored more frequently compared to the previous two election campaigns.

Equality is an important theme that emerges in the health section of this government program. The common usage protocol of health institutions and general health insurance are presented within a framework of equality.

> We carried into effect the General Health Insurance system under which all our people make use of the health services with the same standards, the premiums of the poor are paid by our state and all our children under the age of 18 have health security. We gathered the hospitals under the same roof and made it possible for our citizens to use all health institutions with their health insurance.[47]

While in early government programs there is an emphasis on the deficits of preceding governments in general and in health in particular, in the later two programs of 2007 and 2011, weight is placed on what has been accomplished by the AKP. In two government publications that followed the 2011 elections, *Alnımızın Akıyla* and *Sessiz Devrim*, the actions of AKP governments from 2002 onwards are presented with stress on the government's improvement of

46 "60. Hükumet Programı," 2007, https://www.tbmm.gov.tr/hukumetler/HP60.htm. (See appendix C.22 for the original.)

47 "61. Hükumet Programı," 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm. (See Appendix C.153 for the original.)

health services and their having been made accessible to all citizens regardless of social status, financial capability or social security coverage.

In the booklet *Alnımızın Akıyla*, the actions of the government in transportation, education, and economics are summarized in one - or two - sentence bullet points supported by photos. The health section stresses how the AKP Government is distinguished from its predecessors by its determination to realize these changes, and how actions taken have given citizens easier and more equal access to health services. With respect to the equalization of health services for everyone, the stress is on the common usage protocol.

> We gathered the state hospitals and the SSK hospitals under one roof. We made it possible for our citizens under the coverage of Emekli Sandığı, BağKur, and SSK to make use of all hospitals. We brought an end to the practice of compelling our citizens to first go to doctor's private clinic to receive health services by passing the "Full-time employment Law."[48]

With regard to how, geographic disparities are overcome by the AKP government, it is stated that "with 98 mobile health units and 18 million consulting rooms, we have brought health services to the doorstep of our citizens."[49]

In the same publication the general health insurance system is also presented as a step toward equalizing citizens regardless of their financial status, coverage, or gaps in their social security due to unpaid premiums.

> We made it possible for all our citizens to have general health insurance, even those not under any coverage until then. We provide health services free of charge to everyone below the age of 18. We guarantee that everyone until the age of 18 - regardless of their parents' coverage

48 Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012), 71. (See Appendix C.23 for the original.)

49 "Oluşturduğumuz 98 gezici sağlık birimi ile 18 milyon muayene yaptık. Sağlık hizmetini halkın ayağına götürüyoruz." Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012), 71.

> or whether they have premium debts - would benefit from health services without condition.[50]

The family physician model is also presented as a practice that ensures that all citizens equally have regular medical examination without payment. This practice is mentioned in the publication *Sessiz Devrim* (Silent revolution), the sub-heading of which is *Turkey's democratic change and transformation inventory 2002-2012*: "By carrying into effect the family physician model, all citizens are under constant doctor surveillance free of charge."[51]

Along with these statements pointing to a broad equality and love for the people, the specific changes to practice are also pointed out. The changing practices in the provision of medication to citizens covered by SSK, as a consequence of the transfer of all public hospitals and health units to the Ministry of Health, is frequently brought forward by the AKP as an element of equality. An article that points out the health services provided by AKP up to 2007 states:

> The AKP gathered all the public health units under one roof for the sake of using existing health capacity in an effective and efficient way. By this means, more than 30 million citizens under SSK coverage who until now could obtain services from only 150 hospitals now have the right to make use of all health units. Additionally, they were saved from queuing for medication until late hours of the night and enjoy the right to get their medication from any pharmacy they want. Moreover, state officers, pensioners, and widows can now receive services from private hospitals.[52]

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50 Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012), 73. (See Appendix C.24 for the original.)

51 "Aile hekimliği uygulaması hayata geçirilerek tüm vatandaşların ücretsiz şekilde sürekli doctor gözetiminde bulunmaları sağlanmıştır." T.C Başbakanlık Kamu Düzeni ve Güvenliği Müsteşarlığı, *Sessiz Devrim: Türkiye'nin Demokratik Değişim ve Dönüşüm Envanteri 2002-2012*, (Ankara, 2013), 123.

52 *Türkiye Bülteni* 47 (July-August 2008): 49. (See Appendix C.25 for the original.)

Green Card users were also mentioned in the election bulletins and publications of AKP about changing practices that increased the amount of services by which they are covered. The 2011 election bulletin of AKP states that: "we made it possible for our citizens with Green Cards to make use of public health services just like other insured citizens and made it possible for them to receive their medicines from any pharmacy without restriction."[53]

Similarly, in the 2007 election bulletin states that: "intended for the poor part of the population, the rights of citizens with a Green Card have been extended. Under the adopted regulation, ambulatory health care that receive and the expense of medicines are now paid by the state."[54]

The claim in these two statements is that differences between Green Card holders and other insured citizens that had existed until then were abolished, and their rights were equalized with those of privileged citizens.

In an issue of *Türkiye Bülteni* published in April 2007 it is stated that: "under the government of AKP, ambulatory care services started to be paid by the state and Green Card holders, just like state employees, started to obtain their medication from any pharmacy."[55]

The equality provided to Green Card holders is presented first of all as an achievement of the AKP government. Secondly it is underscored that Green Card holders can now receive the same level of service as state officers, the group with the broadest access and coverage among the three social security schemes. Thus, the statement claims that the most and least citizens are now covered equally thanks to the policies of the AKP.

In making these statements, the role of AKP is presented as a determined actor changing the ways citizens are approached - more equally and given

53 "Yeşil kartlı vatandaşlarımızın tıpkı diğer sigortalılar gibi kamu sağlık hizmetlerinden faydalanabilmesini ve ilaçlarını istedikleri eczaneden alabilmelerini temin ettik." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org.

54 "Dar gelirli kesimlere yönelik olarak yeşil kartlı vatandaşlarımızın hakları genişletilmiştir. Yapılan düzenleme ile Yeşil Kart sahiplerinin "ayakta tedavi" kapsamında görecekleri sağlık hizmetleri ile ilaç giderleri de devlet tarafından karşılanıyor." "AKP 2007 Seçim Beyannamesi," June 2007, 77. www.akparti.org.

55 "AK PARTi iktidarında yeşil kart sahibi yoksul vatandaşlarımızın ayakta tedavi masraflarının devletçe karşılanması ve ilaçlarını tıpkı devlet memurları gibi, serbest eczanelerden alabilmeleri sağlandı." *Türkiye Bülteni* 47 (April 2007): 49.

higher priority - in general and in the health sector. (Transportation and education were equally emphasized by AKP, as well) The AKP not only presents itself as determined but also presents its practices and policy changes as having no precedent. Their claim is that what they did, do, and will do was considered difficult or impossible by predecessors, but because they focus their attention on serving the people no change is impossible. Statements by Recep Tayyip Erdoğan during a pre-election rally held in Bingöl in 2007 concretely demonstrates this viewpoint.

> When we said we would unite the SSK and the state hospitals, the CHP said that it was not possible. As we said before, we said we could do it, and we did it. You can see that as of yesterday there is no discrimination in the hospitals. From now on pensioners, citizens covered by SSK and Bağ-Kur, and Green Card holders can all make use of all the hospitals of this country without discrimination.[56]

Another theme related to equality that comes up in election bulletins and other publications of AKP is the equality of receiving emergency services and the provision of certain free services in private hospitals. This is a significant aspect of the discourse as it underscores how before the AKP even citizens in life threatening circumstances were unequal. The 2011 election bulletin states that:

> Our 74 million citizens can receive treatment without payment in cases where emergency or intensive care is needed, including at private hospitals. Additionally, we made it possible for everyone regardless of their social security coverage to receive all kinds of health care for epidemic illnesses, working accidents, and occupational illnesses without paying a fee. Moreover, our citizens do not pay any fees in private hos-

56 "Biriz Beraberiz" *Türkiye Bülteni* 50 (July 2007): 18-19. http://www.turkiyebulteni.org/PDF/50%2007%20Temmuz%202007.pdf. (See Appendix C.26 for the original.)

> pitals for burn injuries, cancer, treatment of newborn infants, transplantations, congenital anomaly, dialysis and for cardiovascular surgery.[57]

The increase in the number of births in hospitals from 78 to 92 percent is also mentioned in the 2011 AKP Election Bulletin as an indicator of equality: "we are providing financial assistance to poor families who were refused by hospitals before. So now, pregnant and child family members have regular health checkups. Up to today, we have paid 2 billion Turkish lire."[58]

Granting the possibility to receive treatment without payment in the emergency rooms of private hospitals is also underscored as a way of equalizing citizens. Citizens victimized by their financial status or lack of coverage by a social security scheme are now - it is claimed - receiving health services that they could not receive before.

Another point that is underscored in the statements of Recep Tayyip Erdoğan and the government is that citizens can make use of emergency services regardless of their social security coverage. The statement of Recep Tayyip Erdoğan during the opening ceremony of Elmadağ Diversion is an example of how this change of practice is verbalized: "today patients are not rejected at the doors of emergency units."[59] Similarly, Recep Akdağ stated that:

> it is a must of a social state that citizens access health services both easily and free of financial concerns. No one can demand payment from our patients in an emergency room even in a private hospital. If they demand it, they are breaching the regulation. In such cases our citizens should not let themselves be victimized. No one can make our

57 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org. (See Appendix C.27 for the original.)

58 "Daha düne kadar sağlık kuruluşlarından geri çevrilen yoksul ailelerin hamile ve çocuklarının sağlık kontrollerini düzenli yaptırmalarını teşvik için para desteği sağlıyoruz. Bugüne kadar 2 milyar TL ödeme yaptık." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org.

59 "Bugün hastalar acil servislerin kapılarından çevrilmiyor." "Yolları Böldük Hayatları Birleştirdik," *Türkiye Bülteni* 63 (March-April 2010):40.

> citizens sign a debt for such services; no one can tell our citizens in emergency cases that they should pay before being treated.[60]

Both the discourse of the Prime Minister and the Minister of Health are built around the subject of saving victim-citizens and providing them the treatment that they deserved of which they were deprived until the AKP came to power - a discourse mentioned beforehand in this chapter. While the transfer of health units to the Ministry of Health is making it possible for citizens with different social security coverage to make use of more hospitals and health service units than before, making use of the emergency rooms free of charge is presented as a step towards "further equality" with the implication that not even the right to survive was equal for all citizens regardless of their financial status before the AKP.

§ 3.3 Concluding Remarks

The frequently-presented theme of government siding with health care receivers against health care providers – who, it is claimed had not been serving health care receivers as they should have - is a dominant theme that runs throughout the AKP's pro-health reform discourse as can be seen in the specific issues discussed in this chapter such as detained patients and inequalities in the pre-existing health system. The first circular of the Ministry of Health after the formation of the first AKP government in November 2002 regarding the discharge of the patients was not coincidental and was a first step in the portrayal of the divide between the health service providers and health service receivers. The government manifested the requirement of reforming the health system through materializing the malfunctionings of health system in the practice of not discharging the patients who have not made their payments. By underscoring this practice in more than one occasion AKP highlighted their difference from the previous governments in approaching the "people" and portrayed themselves as the protector of them from the service providers.

60 "Özel Hastanelerin Acil Hizmeti Ücretsiz," *Türkiye Bülteni* 67 (November-December 2010): 5. (See appendix C.28 for the original.)

The chapter at the same time analyzed the portrayal of the change of the fractured social security system by the AKP through issues such as the introduction of the common usage protocol, – that allowed the people under diverse social security schemes using the health units they were not allowed to use before the transfer of the SSK hospitals to the Ministry of Health, extension of the rights of Green Card holders and changes in the practices of access to emergency rooms. Government portrayed those achievements as steps towards equal citizenship status to everyone regardless of their social security coverage. The equality brought through the policy changes was equated in the discourses of the AKP with loving the people. Throughout the presentation of the policy changes the AKP positioned themselves as closer to people with regards to their predecessors, and saving them from the injustices that they endured before their governance.

4

Presenting the Novelties and Accomplishments of an "Unprecedented Reform"

> *Our main principle is that until the suffering of a patient ends our suffering does not end. Our citizens fully deserve hospitals, roads, schools, and all other services."*[1]
>
> – Recep Akdağ at an opening ceremony in 2010

1 "Ana prensibimiz, bir hastanın ızdırabı dinene kadar bizim ızdırabımızın dinmemesidir." *Türkiye Bülteni* 62 (January 2010): 5.

> *We started a transformation in health. We have made revolutionary steps in 112 emergency services which come to the rescue of our citizens. We increased the number of ambulances from 617 in 2002 to 2547 in 2011, in order to reach our patients even in difficult conditions. We put into service in Turkey 18 helicopters, 2 plane ambulances, 4 sea ambulances and 132 snow pallet ambulances. It was a dream but it has become reality.*[2]

The previous chapter examined how the AKP's discourse on health reform framed the government's actions as an end to victimizations that were allegedly created and sustained by the health system of pre-AKP governments. As I demonstrate through a discussion of specific issues such as patients detained in hospitals and geographic and social security-based inequalities, there is a discursive emphasis on presenting the AKP as a determined actor in ending "unjust treatment in the health sector." In other words, the previous chapter can be read as how the AKP specifically constructed a coherent narrative of "doing away with the old health system."

This fourth chapter continues the analysis of AKP's discourse on health reform but focuses on what the AKP government presents as its own initiatives in the health system. In other words, the chapter examines the parts of AKP discourse that emphasize "the building of the new health system." In this discourse, the changes introduced to the health system are framed as "novelties" not undertaken by any previous government. Hence, there is a discursive emphasis on portraying health reform as "unprecedented" in Turkey's history. At the same time, in introducing these "novelties" in the health system, the AKP government is presented as a very determined actor that offered services in health (along with education and transportation) that all citizens deserve unconditionally, as reflected in Recep Akdag's statement quoted above. As will be revealed in the discursive analysis of the specific themes outlined below,

2 "AK Parti'nin 3. Sağlık Reklam Filmi - Hayaldi Gerçek Oldu" posted anonymously, May 22, 2011, video, 0:45, https://www.youtube.com/watch?v=lExH90P4mQc.

statistics play a key role in the AKP's constitution of its claims to have succeeded in health reform. In other words, AKP officials continuously refer to statistics (increases in health units, bed capacities, and ambulances and decreases in mortality rates) to proclaim the accomplishments of their government in health-care.

This chapter will analyze the AKP's discourse on novelties introduced to the health sector under three categories. Firstly, changes that promise a more efficient health system will be explored. Four issues are foregrounded in the discourses of the AKP government with respect to a more efficient system: 1) increasing the number of doctors and health personnel, 2) increasing the number and capacity of health-care units, 3) reducing bureaucratic procedures in the health system's operations, and 4) decreasing costs.

Secondly, changes that are claimed to have brought about higher quality health services will be discussed through the publications of the AKP, Ministry of Health, pro-government media, election bulletins and government programs. The theme of quality will be discussed with respect to four issues: the increase in the quality of citizen health, the introduction of new health equipment, introduction of new types of health services, and technological novelties introduced in the health sector. In the third section, discourses on changes that have promoted patients' rights and choice will be discussed.

§ 4.1 Claiming Efficiency

In this subsection health sector efficiency in the discourses of the AKP is discussed through four specific issues that frequently came up in public appearances and in the publications and declarations of the government. The term efficiency was used to signify the ways through which services were provided faster and reached more citizens. The emphasis on efficiency in the discourses of the AKP will be discussed through these four issues: the necessity of increasing health personnel and, until this takes place, how can more citizens receive services with the same number of doctors; concern for increasing the number of health units and the ways that more citizens can receive services with the existing number of health units; the decrease in bureaucratic procedures for citizens receiving health services; and making use of the existing

budget in a more efficient way by decreasing costs in certain areas of the health sector.

4.1.1 *Increasing the Number of Health Personnel*

The necessity of increasing of the number of health personnel and doctors appears often and consistently in AKP statements made on various occasions from the establishment of the first government throughout their successive governments. The issue of a lack of the doctors and health personnel is presented not as a matter that the AKP government – has resolved - unlike the practice of detaining patients in hospitals - but as a concern that is taken seriously for the first time by the AKP. In other words, it is not presented as an issue that is resolved entirely by the AKP but as an issue whose presence they acknowledged and for which steps were made for a resolution by their government.

Various consequences of the lack of doctors and nurses in Turkey are mentioned in the discourses of the government. Alongside the inadequacy of service provision, the insufficient number of health personnel is also mentioned as a disadvantage for advancing health tourism in Turkey.

Recep Akdağ was asked in an interview if the government was considering generating income from an improved health infrastructure in Turkey and whether there was a vision for health tourism in Turkey. He replied that:

> Already we have foreign patients coming to hospitals, especially to those in Istanbul, Gaziantep, Antalya, and somewhat in Ankara. Ophotomology, cardiovascular surgery, orthopedics, and dentistry are particularly in demand. However, we have a disadvantage in this area. There is an insufficient number of doctors and nurses in Turkey. In Turkey the number of doctors is half of what is needed and the number of nurses is a fifth of what is needed. Especially if we want to pave the way for health tourism, we have to permit the recruitment of foreign health professionals. If we increase the quotas for medical schools in Turkey and permit the recruitment of foreign personnel in the coming

> three-to-five years, we will partially meet this need, and 2023 is when we will get out of difficulties.[3]

The lack of doctors and the consequences are frequently cited by the government on diverse occasions. To resolve the question of the inadequate number of doctors, several propositions were discussed by the Ministry of Health in particular and by the government in general. An increase in the number of students accepted into medical faculties, an increase in the number of medical faculties themselves, and permitting the recruitment of foreign doctors are among the propositions made.

During a meeting in Hatay to evaluate the "Health Transformation Program," Minister of Health Recep Akdağ stated that

> among the 53 European countries, Turkey is next to last when ranked according to the number of patients per doctor. In 52 European countries there are 280 doctors for every 100,000 people, while in Turkey there are 140 doctors for every 100,000 people. First of all, these numbers show that the number of doctors in Turkey is insufficient. When we look at annual examinations we see that every doctor examines 50, 60, or even 70 patients per day. It should be recognized that these numbers are very high. All in all, this is a problem for both our citizens and our doctors. It is a pity for the future of the country not to train doctors when there are so many young people waiting to be educated in the universities and when there is such a significant need for doctors. Doctors will never remain unemployed in Turkey, as some people think and claim. For these reasons we should increase the number of our doctors. For the coming year the most important issue in the health sector is the insufficient number of doctors. In this respect, both the authorization and the responsibility is with YÖK (the Council of Higher Education).[4]

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3 *Türkiye Bülteni* 56 (July-August 2008): 31. (See Appendix C.34 for the original.)

4 "Akdağ, hekim açığı için YÖK'ü göreve çağırdı." *Zaman,* December 17, 2006. http://www.zaman.com.tr/gundem_akdag-hekim-acigi-icin-yoku-goreve-cagirdi_473338.html. (See Appendix C.154 for the original.)

In this statement it can be observed that not only is the issue of the insufficient number of health personnel brought forward, but there is also an emphasis on an objection to the proposition to increase the number of doctors. The objections that are implied are those of the TTB with respect to the employment of foreign doctors and the opening of new faculties of medicine without the necessary infrastructure. As mentioned earlier in this chapter, the position of the government is framed as distinct from those of its predecessors in terms of creating solutions that were not considered before, and the government is distinguished from its contemporaries by prioritizing service to the people.

The increase in the number of health personnel in regions that lack personnel is also a frequently mentioned issue , as discussed in the previous section. Recep Akdağ, when asked in an interview in 2003 what types of solutions the Ministry of Health was creating for the regions where health services were insufficient, replied that :

> contracted personnel were hired in the public sector before, but doing so systematically for places where there was an insufficient supply of personnel was done for the first time in Turkey. This is one of the most important steps made in restructuring the public sector, local administrations, and the personnel regime. What we do is create contract positions for regions where we have difficulties recruiting health personnel. These are fixed positions, which means that when the doctor or the health worker is employed, they are employed only to work in that specific province. The contract is made according to that. He cannot have himself appointed to a different province after a short while on some pretext; when starting work, he knows where he will be working and how much he will be paid. Moreover, he is paid a high salary, and as he goes there willingly, it is guaranteed that he will be serve more efficiently.[5]

The issue of insufficient doctors and health personnel has been brought forward often by the Ministry of Health and the Prime Minister from the very early days of the government. When the need to employ foreign doctors was

5 *Türkiye Bülteni* 5 (October 2003): 43. (See appendix C.36 for the original.)

expressed as a solution to the insufficiency of doctors in Turkey, the invalidity of opposing viewpoints was emphasized and underscored by Akdağ and Erdoğan.

The need for foreign doctors are legitimized, as in the statement of Recep Akdağ quoted earlier, by the expansion of medical tourism as well as the low rank of Turkey with respect to the patient-per-doctor ratio compared to European countries. Changing the legislation to make the recruitment of non-Turkish citizens as health personnel possible is presented as a necessity for an efficient functioning health system and as a practice that is frequently encountered in the world. In 2007, during a visit to Nevşehir to evaluate Health Transformation Program practices, Recep Akdağ was asked his evaluation of the recruitment of foreign doctors, and he responded favorably.

> This issue is being discussed by some with slogans. In Turkey, medical tourism is progressing; patients come to Turkey from abroad to be treated. What will we do when our doctors… who are already not enough for us… when they start to be employed for medical tourism? We will have problems if we lose our doctors to medical tourism given that their numbers are already scarce. Doctors coming from abroad can fill a significant gap in this area. We do not see the employment of foreign doctors as the only answer to the lack of doctors in Turkey. The number of students in medical faculties should be increased. Those who state that foreign doctors should not be working in Turkey - those who oppose this solution - unfortunately want the number of doctors in Turkey to decrease. They do not accept an increase in the number of doctors. This is a major contradiction. I wonder whether in Europe or in other parts of the world are there still countries who say that "we do not want foreign doctors in our country"? In what century are we living ?[6]

The point made by Akdağ, besides being in favor of making the health system more efficient through the employment of foreign doctors and increasing the

6 "Akdağ: Yabancı Doktor Gelmesin diyenler doktor sayısı azalsın istiyor," Sondakika, February 17, 2007, http://www.sondakika.com/haber/haber-akdag-yabanci-doktor-gelmesin-diyenler-doktor/. (See Appendix C.37 for the original.)

number of foreign students, is that their standpoint is distinguished from that of their opponents, be they the main opposition party or professional associations and trade unions in the health sector. They are different as they are employing practices that are widely used in the world and are making Turkey a place that is no longer governed by the past. The defining characteristics of the opposing ideas are represented as wanting the country to remain with its issues that need to be handled, and lag behind other countries.

The law concerning the employment of foreign doctors was vetoed after passing through parliament and was returned to parliament by President Ahmet Necdet Sezer in March 2007. The justification for the veto of Law No. 5881 was that it renounced the 'Turkish doctor-centered' health policy for the first time in the republic's history. Additionally, it was seen unfavorably in terms of creating high quality service - doctors would serve without knowing local social facts and conditions. Furthermore, the language question is another element that increased its unfavorableness. Thirdly, the number of doctors are not insufficient but rather unjustly distributed, and it is inappropriate to employ foreign doctors before resolving the employment problems of Turkish doctors. Additionally, adaptation to the EU is not convincing as the change to the regulation does not improve public health and patient security or protect the rights of health professionals; it only allows non-Turkish citizens to be doctors. And lastly, the concern of doctors being insufficiently educated was given as justification for the veto.[7]

The initial reaction of the health minister to the veto emphasized the determination of the AKP government to pursue the Health Transformation Program. When asked about the justifications stated by the president for the veto - and whether they had similar concerns about the language issue for foreign doctors -, he replied:

7 "Sezer'den Yabancı Doktora Veto," *Vatan,* March 2, 2007, http://www.gazetevatan.com/sezer-den-yabanci-doktora-veto-111457-gundem/ "The Press Release from the Office of the President on the Vetoing of certain articles of Law no:5881," https://www.tccb.gov.tr/basin-aciklamalari-ahmet-necdet-sezer/1720/7217/5581-sayili-kanun.

> I am doing my job. I woke up at 5 a.m. and came to Burdur at 6 a.m. today. It is now approaching midnight. I will continue to do my job like this. Our government is determined to realize this transformation program. We are doing our job. Thus, if the law is interpreted in this or that way, it does not concern us.[8]

Despite these determined declarations, the commission working on Law. No. 5881 withdrew the articles concerning recruitment of foreign doctors and health personnel in the following days. The Ministry of Health declared that they had not changed their position in terms of employing foreign doctors, but that

> in order for the other articles, which would increase the quality of health services our people would receive, to enter into force as soon as possible, we are withdrawing the articles that were vetoed to be discussed and reevaluated in parliament later on.[9]

The ministry here underscores that they are withdrawing these articles not because they are convinced by the justifications for their veto but rather to have the other articles of the law come into force so that citizens would not be deprived of improved, more efficient health services in other respects.[10] The withdrawal of these articles can also be explained by the fact that President Ahmet Necdet Sezer was approaching the last months of his term in office at the time of the veto. With the AKP majority in parliament,[11] it was probable

8 "Hükumetin Yabancı Doktor Kararlılığı," March 3, 2007, http://www.aktifhaber.com/hukumetin-yabanci-doktor-kararliligi-104383h.htm. (See appendix C.38 for the original.)

9 "Yabancı Doktorda Farklı Açıklamalar," *Milliyet*, March 9, 2007. http://www.milliyet.com.tr/2007/03/09/siyaset/axsiy02.html. (See Appendix C.39 for the original.)

10 The remaing articles after the withdrawal of the vetoed ones are 3rd,4th, 5th and 9th articles of the Law No:5881 regarding respectively the appointment of doctors in obligatory service as General Practitioners, the working hours of health personnel, independent working arrangement of doctors with certain types of contract and the construction of medical specialization council. "Law No 5881," February 15, 2007, https://www.tbmm.gov.tr/kanunlar/k5581.html.

11 After the 3rd November 2002 parlimentary elections there were 363 AKP MPs, and 178 CHP members of parliament.

that an AKP candidate would be elected as the new president and would not subsequently veto this law.

The law allowing the employment of foreign doctors was passed on 11 October 2011. Before this date, government declarations in favor of employing foreign doctors underlined the need to increase the number of doctors. During the budget presentation of the Ministry of Health, Recep Akdağ underlined the significant insufficiency of doctors in Turkey and stated that:

> Until the YÖK president change, we could not even discuss this issue with YÖK . There was general acceptance in the country that there was an excess of doctors. The number of doctors serving patients was seen as sufficient. Since YÖK accepted the severity of the situation, the number of students in medical faculties has been increasing. DPT and YÖK understood this issue, and we have made steps. Only in 2023 will we have a sufficient number of doctors. In the medium and long run we should train our own personnel. In the short term, the way towards employing foreign doctors should be cleared.[12]

Here it can be noted that once again the emphasis of the Minister of Health is that their determination to make the health system more efficient is being blocked by the bureaucratic remnants of the pre-AKP government. AKP discourse thus focuses on their aim to serve the people despite obstacles created by pre-AKP state institutions. In a statement Recep Akdağ delivered shortly before the passing of the law regarding the recruitment of foreign doctors, he emphasizes how this mentality holds Turkey back from conforming to global standards and receiving deserved services. During the opening speech delivered at a conference entitled "Global Health: 2011- Sustainable and Efficient Health Services" in London, he stated that:

12 "Bakan Recep Akdağ: Yabancı Doktor Şart," Haber7, October 24, 2010, http://www.haber7.com/genel-saglik/haber/648519-bakan-recep-akdag-yabanci-doktor-sart. (See appendix C.40 for the original.)

> Despite a successful Health Transformation Program, there is a deficiency in the number of health personnel in Turkey. Moreover, according to a law that dates to the 1920s, it is forbidden for non-Turkish citizens to work as doctors. We are trying to change this. The nationalist stance in Turkey is trying to prevent it, but we have to make it happen . We believe that in Turkey, people have the right to make use of global science and global scientists.[13]

The nationalist stance mentioned here refers generally to that of the opposition party, the CHP, and in particular to the veto of President Ahmet Necdet Sezer in, as one of the points in the justification of his veto was that it is not appropriate to recruit non-Turkish doctor before resolving the employment questions of Turkish doctor.

The discussion over the number of doctors was not limited to foreign doctors. The need to increase the number of doctors in the public sector, within a framework of obligatory service for general practitioners and specialist doctors, was also put on the government agenda.

During his speech to Parliament for "Doctor's Day" on 14 March 2007, Recep Akdağ pointed to the deficient number of doctors employed in public health units. In response to an opposition party member of parliament who stated that given obligatory service for both general practitioner and specialists, it would be difficult to attract students to medical faculties, Akdağ stated that:

> The scores necessary to become a student in medical faculties are continuously increasing because of excessive demand. Here, under the roof of this holy parliament, we should call to duty the institutions responsible for this issue. I did this many times, and once again using the 14 March Doctor's Day as an occasion, I am doing it again. I especially call on the Council of Higher Education. The number of doctors in Turkey is totally insufficient. There are 53 countries in the European region of the WHO. When we compare these countries according to

13 "Yabancı Doktor Almak Zorundayiz," Gazeteport, September 29, 2011, http://www.gazeteport.com/haber/54904/yabanci-doktor-almak-zorundayiz. (See Appendix C.41 for the original.)

> the number of doctors per 100,000 patients, - the Republic of Turkey is in 52nd place. Yet a professional organization is making the same mistake for twenty years, and still, in a report published at the end of 2006, declares that "the number of students in medical faculties in Turkey is excessive and should be decreased immediately." But please, let's not make the same mistake under this holy roof; we are speaking about the future of our country - the people of the Republic of Turkey. And do Turkish people deserve less health services than these other 53 countries? This deficiency results in a heavy workload and risk for our doctor friends. Regardless of how hard we work, regardless of how devoted we work, this work load is excessive. And because of this I am expecting support from the main opposition party. We definitely need to increase the number of doctors in Turkey.[14]

Despite the fact that Recep Akdağ acknowledges that the aim to increase the number of doctors is not yet realized, this statement is significant. It shows how the AKP government differentiates itself from contemporary political actors in and outside parliament in terms of recognizing the problems of the Turkish health system, and making steps towards resolving them. Both the opposition party and the Turkish Medical Organization, without mentioning the name, were depicted as not understanding the deficiency in the number of doctors and not cooperating with a government that supported ideas to make the system function more efficiently. In relation to this, during the same speech, Akdağ mentioned the veto of articles of a law concerning the appointment of chiefs and vice chiefs in training and research hospitals by President Ahmet Necdet Sezer, and he criticized mp Tandoğan who spoke earlier the same day on the same subject:

> Among the articles vetoed by the president were ones concerning the appointments of chiefs and vice-chiefs. If the members of parliament read these articles they would see this: the rights given to deans of medical faculties and rectors in constituting the academic members of

14 "Recep Akdağ'ın 14 Mart 2007 Tarihli Konuşması," March 14, 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm. (See appendix C.42 for the original.)

> staff has been denied to the Ministry of Health with this veto. All the obstacles placed in this path are obstacles placed on services to be made to the people. You are representing the people here. Hence, you have to accept the actions made by a government that came to power by a vote of confidence of members of parliament elected by the people.[15]

Efficiency in this context is equated with the effort of the government to increase the number of doctors by increasing the number of students in medical faculties and by granting the Ministry of Health authorization to create posts in Training and Research Hospitals so that the number of specialist doctors would increase. Criticisms of these attempts are defined, as mentioned before, as part of a mentality that holds the country below global standards and that prevents people from receiving services that they have the right to access and that they deserve.

During an interview in 2008, Recep Akdağ stressed the importance of having a sufficient number of doctors in the country and mentioned the increase that they achieved:

> This year, the increase of the quota devoted to faculties of medicine from 4500 to 6000 is a significant development. If Turkey continues with this understanding, in 2023 - or in other words, in the 100th year of the republic - Turkey will become one of the three most important health brands in the world.[16]

In order to have a more efficient health system, not only the number of doctors but also of auxiliary health personnel was raised as an issue on the agenda of the AKP government. Especially the disparity among regions in terms of auxiliary health personnel was underlined along with a claim of how this disparity was resolved by the AKP. An issue of *Türkiye Bülteni* published two months

15 "Recep Akdağ'ın 14 Mart 2007 Tarihli Konuşması," March 14, 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm. (See appendix C.43 for the original.)

16 *Türkiye Bülteni* 56 (2010): 26. (See appendix C.155 for the original.)

before the 2007 parliamentary elections under the heading "Health Report Card of AKP Government for the Last 4 Years," stated that:

> While during the 1999-2002 period there were only 39,000 health personnel employed, this number increased to 61,000 in the 2003-2006 period. In areas where no health personnel were sent because of scarcity of health personnel, 16,000 contracted health personnel were appointed. With the new "Appointment and Rotation Regulation" (Atama ve Nakil Yönetmeliği) regions and service groups were formed in order to distribute personnel justly. By determining service grade criteria, personnel transfers were made objectively. For the situations where the health personnel opt for an excuse not to start working a more strict check system was formed. Appointments are now by computer - drawn lots that leave no doubts.[17]

The issue of increasing the number of doctors and health personnel was also foregrounded in the 2011 election campaign. The 2011 election bulletin of the AKP presented the increase place in the number of health personnel during the AKP government in the following way
"We multiplied the number of health personnel; in remote places where there was no doctor, now there are specialists."[18]

At the time of the publication of the bulletin, the law concerning the employment of foreign doctors had not yet passed, but the regulation on obligatory service for general practitioners and specialists had been put into effect on 21 June 2005. Thus, the consequences of this regulation were emphasized. Objectives and promises were made not only for the 2011 parliamentary elections but for the 100th anniversary of the republic, in 2023, as well.[19]

> We will increase the number of doctors, which is now 120,000, to 130,000 by 2015, 155,000 by 2019, and 200,000 by 2023, which is almost

17 *Türkiye Bülteni* 47 (2008): 51. (See Appendix C.44 for the original.)

18 "Sağlık personeli sayısını katladık. Doktor görmeyen en ücra köşelerde artık uzman doktorlarımız var." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 82.

19 2023 aims were launched before the 2011 parlimentary elections.

> double what we have now. We will increase the number of midwifes and nurses, which is 163,000 now to 238,000 by 2015, 310,000 by 2019, and 400,000 by 2023. We will increase the total number of health personnel, which is 650,000 now, to 715,000 by 2015, 853,000 by 2019, and 1.1 million by 2023.[20]

In the 61st government program[21] formed after the 2011 election, these target numbers for health personnel and doctors were mentioned once more.

4.1.2 *Increase in the Number and Capacity of Health-Care Units*

The increase in the number of beds in hospitals, the number of examination rooms, and the number of health units in general was another subject mentioned in government programs, AKP publications, and the statements of government officials on diverse occasions. This subject, like other issues brought to the discussion by the government, initially mentioned the needs of the country that AKP discourse equated with "the immediate needs of the people." The steps made to increase health service units were at times accompanied by comparisons to their insufficiency under preceding governments and were presented within a framework of "serving the people," which was underlined as the distinguishing characteristic of the AKP.

In the early months of the first AKP Government, during the opening ceremony of an Istanbul hospital after its renovation following a fire, Recep Akdağ talked about the insufficiencies of health services in Istanbul, how the problems have compounded, and the governments' outlook on addressing the inability of health care institutions to treat more patients in particular:

> We know that there are deficiencies especially in emergency, transport and intensive care units. Our primary aim is to improve 112 emergency services and intensive care units. It is sad that people are told 'we have no room' and are turned away right after reaching the hospital and

20 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 84, www.akparti.org. (See appendix C.45 for the original.)

21 "61. Hükumet Programı" 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm.

> feeling relieved as they thought they were safe. It is a catastrophe for patients who experience this. This issue does not stem from health personnel, it is about infrastructure deficiencies. To make health services more adequate, the support of private health units will be used as well public services.[22]

The emphasis is on the inadequate number of emergency facilities. The problems in terms of service are not caused by health personnel but by the "approach" before the AKP that did not pay attention to improving infrastructure.

Deficiencies in the number of examination rooms and polyclinics were also mentioned in the first year of the AKP Government and included on the agenda of the government. In an interview conducted with Recep Akdağ in 2003 he stated that the

> Health Transformation Program takes the family practitioner system as its basis and while trying to establish this system, we are at the same time trying to rehabilitate the existing system. To illustrate, in Turkey there are hundreds, thousands of community clinics, yet proper service was unfortunately not provided. In one community outpatient clinic where there were, for example, 8-10 doctors, clinical services and examinations were provided in only one or two rooms. How did we transform this? In a community clinic there should be the same number of rooms as doctors. In hospitals, there was a similar situation. In a hospital where there were 10 specialist doctors, only two outpatient clinics were in working condition. By using every possible space, we are increasing the number of outpatient clinic rooms in hospitals. By increasing the efficiency of our personnel, primarily doctors, we are working to improve the services provided to our people.[23]

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22 "Sağlık Bakanı Akdağ: İstanbul'da acil ve yoğun bakım ünitelerinin sayısını artıracağız." *Zaman*, January 11, 2003. http://arsiv.zaman.com.tr//2003/01/11/marmara/h2.htm. (See appendix C.46 for the original.)

23 *Türkiye Bülteni* 5 (October 2003): 42-43. (See appendix C.47 for the original.)

The increase in health units is framed within the "serving the people" discourse of the AKP Government. The acknowledgement of the need to increase the number of health units and their actual increase are presented like other steps made in the health system as tackled differently by the AKP government than by predecessors.

During a speech on the occasion of 14 March Doctor's Day, AKP member of parliament Osman Akman, after citing the increases in health units in Antalya as an example of how government investments in the health sector are dramatically different than in the pre-AKP period, stated:

> Dear friends, we endeavor to become a party that produces work rather than slogans. If some in the past put bricks for the people in this country we can thank them, but we have no time to spend on single bricks. Tomorrow, we will finish what has been left unfinished and do much better than those who started in the past and come in front of the public with this in mind. We are very peaceful.[24]

The increase in the number of health units as an indicator of increasing investment in health is exemplified in the same speech as follows:

> Dear Friends, it is obvious what we are trying to do for the country. I would like to explain how investments in the health sector are different from pre-AKP governments through the example of Antalya. During our government, we opened the Antalya Dental Health Center in March 2004, the Kumluca State Hospital with 100 beds in April 2005, and Aşır Aksu Hospital with 206 beds in June 2006. We finished construction work on the Serik State Hospital which has 100 beds. Again, I hope in this year in June we will open the Antalya State Hospital for service, which is among the biggest state investments in the center of Antalya. Again, this year we will lay the foundation for the Kumluca State Hospital which will have 100 beds. For the districts of Alanya,

24 "Antalya Milletvekili Osman Akman'ın 14 Mart 2007 tarihli Konuşması," March 14, 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm. (See appendix C.48 for the original.)

> Kaş, Kemer, Finike, and Elmalı, place assignment processes are completed for state hospitals. Hopefully we will do this through public-private partnership. I am not telling the point we have reached with respect to the number of beds as the time allocated for my speech is over.[25]

Akman's statement underlines the difference of the AKP from its contemporaries and predecessors in terms of the successful diversion of state investments towards the health sector, which was not realized before, through the example of Antalya, his own district.

The issue of increasing the number of health units was also emphasized in the following years of the AKP government. As mentioned previously, the health sector took an important place in the 2011 election campaign. The 61st government program announced after a single-party government was formed by the AKP in July 2011 continued to emphasize the health sector. The government program delivered to parliament by Recep Tayyip Erdoğan stated that:

> Half of health space constructed during the republican period, which totals 10.5 million square meters, was constructed during AKP rule. We increased the number of patient beds from 161,000 in 2002 to 201,000 in 2010. The 20,000 already existing patients beds in ward format were converted to a room system with en suite bathroom, and old hospitals are being reregulated in accordance with this model. In this scope, the number of qualified beds of the Ministry of Health has increased from 6 to 30 percent. Our aim is to make all our beds qualified by the end of 2015.[26]

The number of health units constructed and reconstructed are compared to all units constructed since the foundation of the republic, and once more the

25 "Antalya Milletvekili Osman Akman'ın 14 Mart 2007 tarihli Konuşması," 14 March 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm. (See appendix C.49 for the original.)

26 "61. Hükumet Programı," 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm. (See appendix C.50 for the original.)

distinction of the AKP from predecessors is underscored in terms of provision of services not present until their arrival in power.

A booklet published in 2012 by the AKP entitled *Alnımızın Akıyla* indicated the actions of the AKP Government from 2002 until 2012 with bullet points. Among actions covered under the health sector, the increase in the number of health service units comprise a significant number:

> During our governments, we built 2021 new health units, 554 of which are hospitals and 1467 of which are primary care health service units. We increased the examination room number in public health institutions by 400 percent and saved our citizens from long queues for examinations. In 2002, there was 1 specialist examination room for 20,000 patients; now there is one examination room for every 2000 patients. We increased the number of beds in intensive care units which was 869 in 2002 to 9400. The number of rooms with an en suite bathroom increased by 500 percent. We accomplished 18 million examinations with the 98 mobile health units we formed.[27]

In sum, the increase in the numbers of health units was underlined by the AKP on various occasions as steps towards making the health system more efficient, using health personnel more systematically and reaching more patients through increased bed capacities.

Apart from emphasis on increasing the number of health units, there was also a discursive claim of increasing the capacity of existing health units and personnel. The topic of performance-related payment of doctors entered AKP discourse in relation to this claim. Performance-related payment of doctors was presented from the perspective of increasing efficiency. Complementary payment of health personnel through revolving funds were brought to the discussion within a year of the establishment of the first AKP Government together with proposed salaries for contractual health workers –mainly doctors- which was to encourage health personnel to go to eastern provinces with fewer health personnel. These new practices were presented even being in practice

27 Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012), 68-71. (See appendix C.51 for the original.)

solutions to the lack of health personnel in certain regions without resorting to obligatory appointments. The extra payments from revolving funds were proposed as motivation for doctors to serve more patients. In an interview conducted in October 2003, Recep Akdağ declared that:

> All health employees already with contractual positions have the possibility to earn much more than before. In civil service jobs, there is already an increase in salaries, which means this has to do with financial policies. But we are also planning to pay a better wage to health employees and doctors by increasing complementary payments given to them from revolving funds. Law No. 209 is on the revolving funds. We finished the preparation of the draft changes to this law. In the new legislative session, hopefully this will pass. We will provide much better opportunities to share revolving funds with both health employees and doctors. But we have a principle that those with higher performance, who make the patient content - thus the ones who attract more patients, who examine more patients, who make more interventions, more operations and follow-up more patients - will receive more contributions from revolving funds.[28]

The regulation on performance-related payments were introduced as a strategy to use the existing infrastructure and number of doctors -which were presented as insufficient - in the most efficient way possible.

The practice of complementary payments in accordance with measurable performance was initially put into effect in 10 pilot provinces by a directive on the distribution of hospitals' revolving funds prepared in accordance with the Budget Law of 2003.[29] This is defined in the yearly report of the Ministry of Health as follows: "Through this practice, the foundations of a system - that is patient-oriented, that gives the patient the right to choose, and that foresees extra payment for health employees in parallel with the work they perform – is laid."[30] This practice was put into effect on 21.04.2003 in 10 provinces and generalized to whole country by 01.01.2004.

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28 *Türkiye Bülteni* 5 (October 2003): 43-44. (See appendix C.171 for the original.)

29 Türkiye Cumhuriyeti Sağlık Bakanlığı, *Sağlık 2003,* (Ankara, 2004), 30.

30 Türkiye Cumhuriyeti Sağlık Bakanlığı, *Sağlık 2003,* (Ankara, 2004), 31.

During a speech delivered by Recep Akdağ on the occasion of Doctor's Day in 14 March 2005, after the passing of the law on the distribution of revolving funds according to performance, the new practice of performance-related payments was presented from the perspective of making the health system more efficient and making it serve the people better. The example of Eğitim Hastanesi in Ankara was given:

> In this period of time, we achieved changes related to the working conditions of health employees, especially their incomes. The most important of these is performance-related contributions we started to pay to health personnel and doctors –whom we consider as the team leader of health employees. We set up a system whereby our doctors and health personnel in health units –in community clinics, mother-child centers, dispensaries- are employed and receive payments in proportion to their work efficiency. Both individual and institutional performance have increased the incomes of our doctors and health personnel. We have clearly obtained a significant efficiency with this. The number of patients we examined in our hospitals and other health units increased, and when our physical conditions are considered, there was a major need for this. The number of patients treated, operated on, and followed up on has increased. I would like to give some examples. For instance, in Ankara hospital, an educational hospital, only 3500 people were being examined in the outpatient clinics when we came to power, and there were only 40 outpatient clinic rooms in the hospital. Today, in the same hospital, 5000 people can be examined, and there are 120 polyclinic rooms. This has real benefits, in terms of both patients and doctors. Continuing with examples from the aforementioned case, in the beginning a doctor had to examine 80 patients a day in the outpatient clinic; today, despite the increase in the number of patients, a doctor finishes his working day having seen 40 patients. Hence, first of all, doctors can now practice their profession in a more healthy, comfortable way. For the patients, the situation is already clear: the time dedicated to a patient has now increased by a factor of two. We are trying to deploy this all over the country. On one

> side, our health employees and doctors have better working conditions, and our patients have the opportunity of more time face-to-face with their doctors.[31]

The number of doctors, hospitals, and care units related directly with actual health service provision were issues brought to the discussion as objectives in the early years and as achievements in later years of the government. Together with these, elimination of or decreasing bureaucracy was another issue that frequently emerged in terms of increasing efficiency in the health sector. The next section offers a discussion of the discursive emphasis on eliminating bureaucracy.

4.1.3 *Eliminating Bureaucracy*

Within the discourses of the government and the Health Ministry eliminating or decreasing bureaucracy was defined as reducing the number of requirements for citizens to receive health services. Changes that took place in the responsibilities of social security institutions in order to make them more efficient were also presented examples of decreasing bureaucracy.

Reducing the bureaucratic processes to receive services was presented as a part of a broader framework of providing better services to the people - or in other words, better serving people who were deprived of services that they deserved due to policies that, in the words of AKP, did not put people at the center of their objectives.

The issue of decreasing bureaucracy is introduced in not only government policies on health services. The moves in health services towards reducing the bureaucratic steps to access services and inclination toward a more localized administration should be considered within a greater framework of transforming public administration under AKP governments. Thus, before discussing how efficiency and better service of the people is underlined within the discourses of the Ministry of Health and the government via decreasing bureaucratic procedures, a brief introduction to the regulations and circulars issued on public administration in general, and health in particular, is necessary.

31 "Recep Akdağ'ın 15 Mart 2005 tarihli Konuşması," https://www.tbmm.gov.tr/tutanak/donem22/yil3/bas/b070m.htm. (See appendix C.172 for the original.)

A regulation adopted by the Council of Ministers entitled "The Procedures and Principles to be Followed in the Provision of Public Services" was published in the government gazette on 31.07.2009. The first article defines the aim of the article:

> The aim of this regulation is to lay down the basis of procedures and principles in order to form an effective, efficient, accountable public administration that relies on the citizen's statement and to ensure that public services are fast, of high quality and simplified, and cost efficient.[32]

With this perspective, circulars were issued by the Ministry of Health dated 04.11.2008, 28.08.2009, 18.11.2009, 19.04.2010, and 30.05.2011. In the circular dated 30.05. 2011, titled "Decrease of Bureaucracy and Works on Simplification of Administration," it is declared that in line with the previous four circulars, public service inventory and standards charts the prepared and posted on the websites and doors of establishments under the Ministry of Health. In the same circular, it is stated that reducing bureaucracy and the simplification of administration will be realized within the frame of a regulation entitled "Kamu Hizmetlerinin Sunumunda Uyulacak Usül ve Esaslara İlişkin Yönetmelik,"(Regulation Regarding the Procedures and Principles to be Followed in the Delivery of Public Services) and the following articles should be complied with.[33]

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32 "Kamu Hizmetlerinin Sunumunda Uyulacak Usül ve Esaslara İlişkin Yönetmelik," http://www.resmigazete.gov.tr/eskiler/2009/07/20090731-1.htm. (See appendix C.156 for the original.)

33 Article 3, which states that public services should be provided at the first stage and as close as possible to citizens; Article 4, which states that public services should be provided in an electronic environment; Article 5, which states that citizens should be informed about available public services through websites; Article 6, which states that service standards should be constituted and should be announced to citizens at the entrance points to service units; Article 7, which states that the disabled should be provided with the necessary measures to ease their access of services; Articles 8 and 9 state the sufficiency of the self-statement of the applier and inform the applier about his responsibility that if the self-statement is contrary to fact, then legal action will be initiated; and lastly, Article 10, which states that service receivers should

The changes introduced and announced through the circulars and regulations on the administration of health services were described and explained as steps towards making health services more easily accessed by the people. Additionally, it was claimed that through increased efficiency and fewer bureaucratic procedures, more people can access health services.

During an interview on the unification of hospitals belonging to different public institutions, mainly to the SSK, Recep Akdağ responded when asked how people with SSK coverage will apply to hospitals in the new circumstances by stressing the decrease in bureaucratic procedures that patients have to go through to receive services.

> With this unification, the bureaucratic procedures for citizens with SSK coverage to access health services did not increase. On the contrary there are new amenities provided to them, and in terms of accessing health services, all our citizens are brought together on a common platform. Our retired citizens under SSK coverage with their health certificates, those still working by taking a medical visit form from their workplaces can apply directly to any health unit that is attached to the Ministry of Health and receive the service they deserve. In cases of emergency, no medical visit form will be asked for. When citizens with SSK coverage are referred to university hospitals from health units attached to the Ministry of Health, they do not need any additional referral from the SSK.[34]

In this statement the steps that decreased for a citizen with SSK coverage to receive services from health units attached to the Ministry of Health is underlined in a new setting that brought together health services that were previously administered separately.

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be informed about their financial obligations. "Kamu Hizmetlerinin Sunumunda Uyulacak Usül ve Esaslara İlişkin Yönetmelik," http://www.resmigazete.gov.tr/eskiler/2009/07/20090731-1.htm. (See appendix C.156 for the original.)

34 *Türkiye Bülteni* 22 (March 2005): 22. (See appendix C.174 for the original.)

Before the transfer of health units to the Ministry of Health in the 59th Governmental program, the need for their transfer –without directly mentioning it- was explained by the bureaucratic workload they created for social security institutions.

> Dealing with health-related issues prevented social security institutions from performing their fundamental role, and this made them inefficient. Our present health system, with its institutional structure, functioning, personnel structure, and distribution, cannot meet the need. Our government is determined that by making essential changes we will construct a health system that is of high quality, efficient, and accessible to everyone.[35]

The presentation of hospitals belonging to SSK and other institutions as a significant step towards equality among citizens through the discourses of the government and the Ministry of Health has been discussed in the subsection devoted to equality. The same issue is presented here as a move that allows social security institutions to perform better, as there bureaucratic workload would decrease with the transfer of health institutions attached to them to the Ministry of Health, allowing them to work more efficiently as social security institutions.

The impact of changes that took place in the health sector in terms of decreasing the steps for citizens to access health services are presented as achievements realized by the government to make the health system work more efficiently and serve the people better. Changes that would take place to the ways of obtaining medication that followed a circular issued by Prime Minister Recep Tayyip Erdoğan entitled "The Efficient Provision of Health Services" dated 17 March 2005, were presented from this viewpoint.

The circular was issued following the transfer of the SSK and other institutional hospitals to the Ministry of Health, and the rationale was stated in the following way:

35 "59. Hükumet Programı," 2003, https://www.tbmm.gov.tr/hukumetler/HP59.htm. (See appendix C.52 for the original.)

> Following the enaction of "Law No. 5283 on the Transfer of Health Units Belonging to Some Public Establishments and Institutions to the Ministry of Health," in order to efficiently meet the increasing demand for services, to ease operations related to treatment processes, and to increase patient satisfaction, it is suitable to take the following measures.[36]

Because citizens with SSK coverage were able to receive services from all public hospitals after the transfer of these hospitals, the number of patients applying to hospitals increased. The circular can be considered a response to opponents to the transfer of these hospitals to the Ministry of Health. One of the reasons for opposition was that the transfer was realized without infrastructural preparations, so physical and personnel structure would not be sufficient to provide service to the patients that would come following this new regulation. According to this circular:

> From patients with coverage by Emekli Sandığı, Bağ-Kur, SSK, and Green Cards, no health certificates, health ID cards, medical visit forms, or ID photocopies would be requested, which is a practice that increases waiting times, prolongs the treatment process, and has no legal basis. Such checks would be done by the responsible person in the admissions office by comparing the patient to his health certificate. If it is noticed that these controls are not carried out correctly and there is a public nuisance as a consequence, administrative and judicial actions will be taken against the officers.[37]

36 "Sağlık Hizmetleri Sunumu ile İlgili Başbakanlık Genelgesi," TTB, March 17, 2005, http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=268:saikhmetler-sunumu-e-gbaakanlik-genelges&catid=3:tebligenelge&Itemid=35. (See appendix C.53 for the original)

37 "Sağlık Hizmetleri Sunumu ile İlgili Başbakanlık Genelgesi," TTB, March 17, 2005, http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=268:saikhmetler-sunumu-e-gbaakanlik-genelges&catid=3:tebligenelge&Itemid=35. (See appendix C.54 for the original)

Additionally the same circular states that no photocopy of the health certificate, medical visit form or identity card will be asked from patients covered by Emekli Sağlığı, SSK, Bağ-Kur and Green Card; and no additional document other than the prescription would be asked for from patients by pharmacies for the supply of medication. For prescriptions and referral documents, the signature and stamp of the doctor will be enough. Further confirmation from the chief physician will not be demanded.[38]

Following this circular, the discourses of pro-government newspapers and the Ministry of Health underlined that given the new measures taken in the administration of the health system, the most important outcome is a simplified service provision to citizens. In a newspaper article published on 18 March 2005 in *Yeni Şafak*, the circular is summarized, and the title of the article suggests that a decrease in bureaucracy is being introduced in this: "The Queues for Bookkeeping Operations in Health are Coming to an End."[39] In a booklet published in 2012 by the AKP which summarizes the actions of AKP governments from 2002 to 2012, the changes that took place in the administration of health services are summarized underlining the reduction of bureaucratic steps: "First of all, we cured the unhealthy bureaucracy of our health structure; now, with a Turkish ID number, all operations and tasks can be processed."[40]

The AKP discourse presented its "new" understanding of public administration in general and health in particular primarily as a means to provide better service to the people. It also positioned it as the opposite of "the old system" where the people-it claimed- could not receive services and where the process to receive health service was complicated and obstructed access.

4.1.4 *Decreasing Costs*

Serving citizens better is in the backbone of all AKP discourses on health. As already discussed, the claims of increasing efficiency in the health sector were presented with this primary of goal of serving citizens and entailed specific

38 "Sağlık Hizmetleri Sunumu ile İlgili Başbakanlık Genelgesi," TTB, March 17, 2005, http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=268:saik-hmetler-sunumu-e-gbaakanlik-genelges&catid=3:tebligenelge&Itemid=35.

39 "Sağlıkta Kırtasiye Kuyruğu Bitiyor," *Yeni Şafak*, March 18, 2005.

40 Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012), 68.

issues such as increasing the number of health personnel and the number and capacity of health units as well as decreasing bureaucratic procedures. In addition to these, another topic entered the AKP's discourse on increasing efficiency in the health sector: decreasing costs.

One of the most frequent AKP criticisms of the health system was that due to its fractured system, the costs of the system were higher. The AKP argued that there was a need to decrease administration costs and costs in general in order to change what it frequently presented as the cumbersome structure of the Turkish health system.

The high costs of the previous health system and the need to decrease these costs emerged in government discourses with respect to various facets of the health system. These discourses emphasize how steps made by the government prevent uncontrolled expenditures and how system resources will be used more efficiently.

Cost decreasing measures in the health sector are without a doubt an issue that needs elaborate discussion. However, this chapter looks at how health sector changes that took place during the 2002-2011 period were presented and framed by the AKP government within a broader discourse of the party. Thus, through selected party publications and the speeches of AKP members of parliament and the Minister of Health, this section will examine how issues of cost cutting are presented and what type of discourses are produced through those presentations. The most frequently emerging theme to explain financial measures taken by the government in the health sector is the prevention of the "waste" of resources, as will be demonstrated through examples provided in this section.

As an initial consequence of the "funding package,"[41] measures regarding the contribution margins of medicines emerged as an issue. According to this package, medicine contributions would be deducted directly from the salaries, and equivalent medicines would be used. New measures were introduced regarding antibiotics usage, and prescriptions were to be controlled. Objections to these new measures were immediately rejected by government officials. The

41 "Kaynak Paketi." *Milliyet*, January 1, 2003. http://www.milliyet.com.tr/2003/01/09/ekonomi/aeko.html.

statement of Recep Akdağ during an opening ceremony on the 8th Hemophilia Days is as an example :

> The decisions of our government are being interpreted as being savings from health. If most of the health expenditures of a country are devoted to medications, there is something wrong with that. A great part of health expenditures –which are already low- are devoted to medication, as medication consumption is done unconsciously. We already have low health expenditures compared to developed countries, so if within these expenditures medicine expenses go up to 40 percent, there is a mistake there. Savings will be made by reasonable medicine usage.[42]

Here, the cuts, and the increased control measures on the usage of medicines are presented as actions to construct a health system with standards to those of developed countries. It is claimed that the decrease in expenditure on medicines does not imply a cut to "health," itself; on the contrary, they are framed as attempts to initiate the conscious use of medicines, eventually leading to more effective and preventing "waste."

The topic of preventing waste in health expenditures emerged in other issues in the health system. Waste of resources is often underlined, and cost-cutting and other measures regarding the administration of resources - such as the transfer of SSK and other institutional hospitals to the Ministry of Health - are explained as steps to prevent the waste of resources that were not carried out before. During a speech on the occasion of Doctor's Day, AKP member of parliament Turan Çömez emphasized the significance of the unification of administration under and auditing by the Ministry of Health. He touched on the issue of finances in the health sector from this perspective:

> The administration and auditing in health should be gathered in one institution, namely under the Ministry of Health. Health expenses should be disciplined; services and products should be standardized.

42 "Bakan Akdağ: İlaçta tasarruf değil, bilinçli kullanım istiyoruz," *Zaman,* April 18, 2003. http://arsiv.zaman.com.tr//2003/04/18/haberler/h9.htm. (See appendix C.55 for the original.)

> By this means, the losses and leaks prevented should be utilized within the system, and especially the personal rights of health employees must be improved.[43]

Transfer of health institutions, the majority of which were SSK hospitals, is an issue discussed in the previous chapter as part of the AKP's discourse on bringing equality to citizens. In this example, the same transfer of SSK hospitals is justified as a means to gather health administration under one body, the Ministry of Health, and to prevent losses stemming from unnecessary administrative costs and potential corruption due to a lack of auditing.

Another emphasis on preventing waste of resources is through the family practitioner model. During an interview in 2003, Recep Akdağ stated that:

> The family practitioner model is the most prioritized issue of our ministry… As patients will all have a regularly - updated file with the family practitioner they choose, the doctor will know his patient better and also waste in health will be prevented to a large extent.[44]

What is meant by the prevention of waste is that family practitioners will become the first point of application for patients. They will be referred to second and third tier health units only if their treatment cannot be resolved by the family practitioner. Hence, this practice decreases applications to secondary health units; thus, the expense of treatments and examinations in these units would be reduced. During the same interview, the minister stated that as the purchase of MR and other screening devices was not possible within the present budget, existing ones were rented from the private sector together with their operation. With regard to this practice, the minister declared that "they claim that we are transferring the means of the state to the private sector, but on the contrary we are making it possible for people to make use of private sector facilities."[45]

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43 "Turhan Çömez'in 13 Mart 2003 Tarihli Konuşması," March 13, 2003, https://www.tbmm.gov.tr/tutanak/donem22/yil1/ozet/045.htm. (See appendix C.175 for the original.)

44 *Türkiye Bülteni* 5 (October 2003): 41. (See appendix C.176 for the original.)

45 *Türkiye Bülteni* 5 (October 2003): 45. (See appendix C.177 for the original.)

There is an indirect justification for not purchasing these devices for public health units but rather for making outsourcing agreements with the private sector to bring these devices into the service of the people. Thus, there is an emphasis on decreasing costs through cooperation with the private sector and a claim that the need for more devices is written resolved with a smaller budget.

Decreasing expenses via reducing the price of medicine is another issue that can be shown as an example of the government approach to avoiding "waste." As mentioned in an issue of *Turkiye Bülteni* published before the 2007 June general elections, savings on pharmaceuticals of up to 2 billion lire a year is stated among AKP achievements in the health sector.

> A Reimbursement commission was established under the chairmanship of Ministry of Finance, and a 'Single Reimbursement System' opportunity was provided. With the common decision of reimbursement institutions, a new rule of reimbursing at most 22 percent more of the equivalent medicine is made. With this practice, companies remaining outside the reimbursement scheme, in order to be covered by public reimbursements, lowered their prices willingly. With these practices, approximately 2 billion lire of public finances has been saved.[46]

A discussion of how this decision, along with the other regulations, was perceived will be considered in the following chapter regarding opponents to the health policies of the AKP government. But it should be noted here that in all the examples cited on the issues of cost cutting and efficiency, the government initially claims to provide more services and reach more people with existing resources before initiating larger investments in health care such as increasing the number of health care employees.

The last examples on the issue of saving public finances spent on health services are the introduction of home care and changes introduced in preventive health care services. In the 61st government program announced in July 2011, the prospect of decreasing health care costs and creating a cost-effective health care system is mentioned:

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46 *Türkiye Bülteni* 47 (April 2007), 51. See Appendix C.178 for the original.)

> In order to protect our citizens from diseases and high treatment costs, we will introduce a comprehensive "Preventive Health Strategy." We will extend the "City Hospitals" we have started to establish in order to increase service quality and provide cost-effective health service to the whole country. With practices such as home care and telemedicine, we will increase the quality of health services and decrease the costs.[47]

In sum, the cost-decreasing moves of the government are presented within a framework of providing services in a more effective way with existing resources and providing an unprecedented, better, and broader service to citizens.

§ 4.2 Claiming Quality

The increase in quality of the health system overall is another theme that emerges in AKP discourses. Quality changes introduced in the health system, such as the ones discussed in the previous section to increase efficiency, are claimed to be steps made by the AKP that have no equivalent when compared to predecessors . This difference is described as stemming from the distinct characteristic of the AKP that places the "human" at the center of their general way of governing, which is reflected in the health sector as in other areas.

The claim of increasing the quality of health services will be discussed around four themes in this subsection. These discussions will revolve around how these claims are framed and presented, and how those presentations relate to the general discourses of the AKP in terms of "serving citizens." The first theme concerns steps made by the government to improve the quality of health of citizens, such as vaccination practices, mother-child health, regulations on tobacco usage, and campaigns to combat obesity. The second theme is the increase and improvement of equipment such as air ambulances, weather resistant ambulances, better-equipped hospital rooms. The third theme covers new services introduced to the health system and the claim of

47 "61. Hükumet Programı," 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm. (See appendix C.56 for the original.)

increased quality as a consequence - focusing mainly on the family practitioner model and other services such as home care. The fourth theme consists of new technological and information services introduced in the health sector and how these are claimed to increase health service quality.

4.2.1 *Increasing the quality of citizens' health*

During the launch of the measles vaccination campaign run by the Ministry of Health and UNICEF, Minister of Health Recep Akdağ delivered a speech regarding the position on vaccination in Turkey. This campaign aimed to vaccinate 20 million children and was claimed to be the largest such campaign in Europe. During his speech, Akdağ stated that:

> In Turkey there has been important progress in terms of vaccination, but we have seen a decline in the past few years, and our aim for 2004 as the Ministry of Health and the government is to reach the highest possible target not only for measles vaccinations but for all childhood vaccinations. And we have done the necessary studies for that.[48]

Minister of Education Hüseyin Çelik stressed during the launch of the campaign the importance of health service provision to young citizens in order to maintain healthy generations as Turkey has a young population. At the same time, he compared the struggle with disease to the struggle with terrorism and forest fires, as there remains little to be done after they happen; one should be prepared before their arrival. Alongside the two ministers, the Director General of the Basic Health Services Unit of the Ministry of Health emphasized the significance of vaccination, as every 3-4 years there are measles epidemics and 3 out of every 100 children die.

In this vaccination campaign, ministers stressed their concern for improving health by taking into account the population structure of Turkey, and there is even an indirect emphasis on their distinct approach to health services. In this case, the claim of the Minister of Health is that this campaign is the broadest in Europe, and by comparing diseases to terrorism underscores their distinct approach to the struggle with diseases.

48 *Türkiye Bülteni* 8 (January 2004): 47. (See appendix C.57 for the original.)

In terms of increasing the quality of health, mother-child health is an issue frequently brought up in AKP discourses. This issue is brought up mostly with data that shows how mother-child health has improved under the AKP governance. In the 2007 AKP election bulletin, the section on health starts with the following statement:

> The Justice and Development Party accepts health services as a basic human right. No human being can be deprived of this right. The duty of the social state is to take all necessary precautions to implement this right. The AKP government made important steps on this issue and considered the provision of health services in the best way as a fundamental duty. For healthy generations, the AKP has achieved unimaginable success on the way to a more just society, with higher quality and easier access to services.[49]

On the issue of mother-child health it is stated that:

> We have lowered infant mortality rates from 29 per thousand to 22 per thousand and mother deaths from 70 per 100,000 to 28 per 100,000, which we place special importance. By 2010 we will lower infant death rates lower than 20 per thousand and mother deaths to below 20 per 100,000. We will increase child vaccination rates above 95%. We will not only implement the vaccination schedules of developed countries but will continue to bring our children the latest novelties and technologies in vaccination.[50]

The statement on mother-infant health and child vaccination issues in the election bulletin demonstrates the emphasis of the AKP is that the quality deserved by citizens has been delivered to them with unprecedented success is part of the AKP's general viewpoint on health where it prevents citizens from being deprived of their right to health.

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49 "AKP 2007 Seçim Beyannamesi," June 2007, 76. www.akparti.org. (See appendix C.58 for the original.)

50 "AKP 2007 Seçim Beyannamesi," June 2007, 78. www.akparti.org. (See appendix C.59 for the original.)

The success exemplified by the statistics is defined as unimaginable and be considered part of the broader discourse of the AKP on health. The emphasis is particular services are provided, and the outlook on health in general is distinguished from that of its predecessors as the main concern of the AKP is claimed to be to serve the people.

In addition to emphasis on decreased mortality rates, their success is underlined by comparing the time frame in which it has been achieved to the average for OECD (The Organisation for Economic Cooperation and Development) countries.

Another issue in terms of increasing the quality of citizen health is campaigns to decrease obesity and reduce tobacco and alcohol consumption. Especially in the 2011 AKP election bulletin and, following the elections, in the 61st government program, objectives that were accomplished and the aims for 2023 were stated for both tobacco consumption and obesity. Success is emphasized through statistical information provided:

> Since 2008, when we started the "smoke free airspace" implementation over 2 million people have quit smoking. The number of smokers over the age of 15 decreased from 16 to 14 million. While in 2009 the total number of cigarettes consumed in Turkey was 107 billion, this decreased to 93 billion.[51]

Aims for 2023 were stated:

> To decrease addiction to tobacco, alcohol, and other drugs, we will continue to combat the risk factors that lead to these. Still, every 27 out of 100 people over the age of 15 smokes. We will decrease this below 23 percent by 2015 and below 15 percent by 2023. For the struggle with obesity, we will start campaigns in schools.[52]

The statistics provided are used to underline the success of the AKP Government in decreasing addiction to tobacco and its determination to introduce

51 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org. (See appendix C.60 for the original.)

52 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 85, www.akparti.org. (See appendix C.61 for the original.)

new practices through legal regulations, all the while emphasizing their claim to an increase in the quality of health.

4.2.2 *Increasing the Quality of Infrastructure and Equipment*

The notion of quality and increasing quality are issues of infrastructural change in hospitals and patients rooms and in the purchase and provision of certain equipment by the Ministry of Health that were not supplied before the AKP governments. The introduction of new equipment is similar to other actions in health services as it is presented within AKP discourse as a step made to serve the people better and to highlight that AKP's distinct characteristic is to position citizens at the center of its actions. However, new opportunities furnished to providers are also mentioned in AKP discourses. In his speech delivered on the occasion of "Doctor's Day," Recep Akdağ stated that:

> I would like to express that, for the last five years, we have been implementing a significant transformation program. I would like to express my gratitude to parliament and to health employees for their support on this very meaningful day in front of the Turkish nation. We have made many improvements with the "Health Transformation Program" together with the support we receive. Meanwhile, by providing a room for every doctor, for every doctor friend - providing doctors and other health employees with new opportunities in terms of using new technologies - the professional satisfaction they receive has greatly increased.[53]

This was a response to the statement of a CHP member of parliament regarding complaints he receives from doctors due to changes to employment regulations concerning full time employment and his argument that the problems in the health system cannot be resolved without resolving the problems of doctors. On the one hand, the response of the minister underlines the significance that doctors and health employees have for them, but on the other, he

53 "Recep Akdağ'ın 13 Mart 2008 tarihinde yaptığı konuşma," March 13, 2008, https://www.tbmm.gov.tr/tutanak/donem23/yil2/ozet/077.htm. (See Appendix C.62 for the original.)

replies that the government provides better working conditions for providers and so, indirectly, how the government has provided better service to the people.

The discussion of the formulation of opposing arguments to government changes to health policies will be dealt with in detail in Chapter 5, but it should be noted that the pattern of government responses to those arguments focus on the main, unchanging priority of the AKP to serve the people or be a "servant of the nation;" thus, all other issues are of secondary importance.

The achievements in terms of providing fully-equipped hospital rooms are presented through percentage increases, giving a concrete idea of the progress made by the AKP Government.

In the prospects on 2023 –the 100th anniversary of the foundation of the republic, which emerged as a major target year for the realization of AKP achievements during the 2011 election campaign- it is stated that: "In 2002 the number of rooms in hospitals with a bathroom was 9 percent; today it is 30 percent. By 2023 we are aiming to have all hospitals rooms with at most two beds and with en suite bathrooms."[54] This objective of fully-equipped rooms was advanced in 2015 in the 61st government program:

> The old hospitals are being arranged to have patient rooms instead of a ward system. Within this scope, qualified beds increased from 6 to 30 percent. Our objective is to make all of our beds qualified by the end of 2015.[55]

In a booklet published in 2012 entitled *Alnımızın Akıyla 9.5 Yıl* which can be translated "A proud 9.5 years" this rate is reformulated for more impact: "We

54 "2002 yılında hastanelerimizdeki nitelikli yatak oranı %9 iken, bugün %30dur. 2023 yılında sağlık kuruluşlarımızdaki tüm hasta odalarını en fazla iki yataklı, banyolu ve tuvaletli hale getirmiş olacağız." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 85, www.akparti.org.

55 "61. Hükumet Programı" 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm. (See appendix C.179 for the original.)

transformed hospital rooms from a ward system to real hospital rooms. We increased the number of rooms with their own bathroom facilities by 500%."[56]

In the 2011 election bulletin, both achievements in the health sector in terms of improving hospital infrastructure and promises for the next parliamentary term are mentioned. The steps made by the government are described as providing citizens both with what they already deserved and with what could not be imagined until then:

> We constructed and continue to construct hospitals that provide the comfort of five-star hotels. We are furnishing our health units with the latest technological equipment. We transitioned from a ward system to a room system in hospitals. While there were 7000 rooms with a en suite bathroom after 80 years, we multiplied this 80 year old number by 4 in eight years, and we have reached 30,000.[57]

In addition to providing citizens, the receivers or the people with what had not been provided to them before, the AKP Government's aims are presented as beyond the next parliamentary term and beyond comparison with preceding governments of the last decade. During the 2011 election campaign, 2023 was presented as the target for AKP promises rather than the next parliamentary term. Thus, in terms of both increasing quality in particular and achieving broader targets in general the AKP delineates itself as an actor with long-term plans for the country and the people. The comparison of achievements in terms of improving hospital rooms is given with the numbers of such rooms in 2002 when the AKP first came to power. But the achievement of the AKP is then compared not only with regard to the last 8 years but with what has been achieved since the foundation of the republic-, a comparison of what has been achieved in the last 8 years versus the last 80 years.

Hence it can be argued that the changes to hospital rooms is a means for the self-presentation of the AKP as an actor that is fundamentally different

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56 "Hastane odalarını koğuştan gerçek hastane odasına dönüştürdük. İçinde banyosu ve tuvaleti olan oda sayısında %500lük artış sağladık." Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012), 70.

57 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 82, www.akparti.org. (See appendix C.180 for the original.)

from preceding political actors, the core motivation of which is defined as serving people who were previously deprived.

Increasing the numbers of ambulances and helicopter ambulances - and the medical carriage and treatment equipment more generally - is an issue worth mentioning when examining the increasing quality of health services. Changes to emergency services, the increase in the number of ambulances, and the addition of new types of ambulances are mentioned with a special emphasis, especially during election campaigns. But before discussing how this issue is highlighted during election campaigns, it is worth noting that even in the first report of the Ministry of Health, the emergency help services were presented as a significant government achievement.

> The 463 existing emergency help stations were increased by 26 and reached 489; the number of ambulances was increased from 613 to 949. For doctors who work in the emergency services an "emergency physician" certificate program has been prepared. Local means have been have been put into use for ambulances and as a first step Istanbul Metropolitan Municipality ambulances have been integrated into the 112 Emergency services.[58]

This shows the significance attributed to emergency services by the government. However, the most remarkable mention of the introduction of more ambulances and changes to emergency services was during the 2011 AKP election campaign. More ambulances and the addition of special ambulances that can easily reach remote villages in severe weather conditions show how the lives of citizens are saved and given a priority incomparable with that of before. In the AKP Election Bulletin for the 2011 elections, the section on ambulances states that:

> The number of our ambulances was 618 in 2002, in 8.5 years we increased it by 4 to 2547. Before we came to power our citizens had to pay to transfer their patient to hospital with an ambulance. There were

58 Türkiye Cumhuriyeti Sağlık Bakanlığı, *Sağlık 2003,* (Ankara, 2004), 9. (See appendix C.181 for the original.)

> no ambulance services for the villages. Now we reach villages with ambulances free of charge and even if needed we do so with air ambulances of which we have 20. Back in 2002 the number of patients transferred by ambulance was 350 000 but in 2010 we carried 2.1 million people, so we increased it 6 times.[59]

The comparison between the emergency services before and after the AKP Government is highlighted with the number of ambulances, the number of patients carried in them, and also the difference in practices. Emergency health services are claimed to be delivered to rural areas only after the AKP period. Regardless of the objective data on the presence of emergency services in rural areas, this discourse is in itself in line with the main argument of the AKP that it places people at the center of its actions, highlighting a delineating feature of its politics from contemporary and previous political actors in Turkey. Especially air ambulance service is put forward as a service that saves people in a way that has no prior equivalent. After the formation of the government, in the 61st government program details of the air ambulance system were mentioned:

> We initiated the air ambulance service in 2008. Since July 2011, we have 19 ambulance helicopters and 2 ambulance planes that operate for the whole country. With the air ambulance system, we have carried 10 000 patients and injured people to-date, and by 2011 we will be adding 3 more planes to our fleet.[60]

The significance of the air ambulance system in AKP discourses on health during the 2011 election campaign is worthy of note. Among the short videos on health prepared for the elections, three are on air ambulances and changing emergency services. These short videos converge on the significance of emergency services and highlight that there is a radical difference on that issue when compared with the pre-AKP period.

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59 "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 84, www.akparti.org. (See Appendix C.182 for the original.)

60 "61. Hükumet Programı" 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm.

In the first video, an empty highway is shown and from behind a hill dozens of ambulances appear one row after the other. Shortly after, there is a scene showing the inside of the ambulance followed by the take-off preparations of ambulance helicopters and ambulance planes. Then the helicopters start to fly over the ambulances, and after the helicopters two planes pass over them. Then the screen is divided into six, and photos of ambulances, snow ambulances, helicopters, and planes are shown. Meanwhile a male voice says:

> We started a transformation in health. We have made revolutionary steps in 112 emergency services which come to the rescue of our citizens. We increased the number of ambulances from 617 in 2002 to 2547 in 2011 in order to reach our patients even in difficult conditions. We put 18 helicopters, 2 plane ambulances, 4 sea ambulances and 132 snow pallet ambulances into service in Turkey. It was a dream but it has become reality.[61]

In this 45-second video, the increased number and new types of ambulances are presented with dynamic music, showing all the ambulances, helicopters, and planes together underlining the strengthened health system. With the introduction of new equipment it is claimed that people are served in a way that has no previous equivalent. The other two short videos, on the other hand, focus on individual stories of "people" that experienced these novelties, specifically new emergency vehicles; the plane ambulance and the snow pallet ambulance.

In the first of these videos on emergency services, the story of a teenage boy in Urfa is described by him and his father. The name of the boy is written and it is specified that he is a student. First his father is shown in a place with a panoramic view of the city, and during the video the father and son are shown feeding fish in the famous Balıklı Göl in Urfa and the boy is shown walking at the Balıklı Göl by himself in his school uniform with books in his hand. His father starts telling the story:

61 "AK Parti'nin 3. Sağlık Reklam Filmi - Hayaldi Gerçek Oldu," posted anonymously, May 22, 2011, video, 0:45, https://www.youtube.com/watch?v=lExH90P4mQc.

> Our son went from school to help his brother. Instead of attaching the trailer to the engine, he lifted it with the chain and his fingers were chopped off. They lifted the engine, took his hand and brought him to Urfa.

Then the boy who was injured continues:

> We immediately went to the hospital in Urfa, there they referred us to Ankara. From there we went to Ankara with the ambulance plane. The ambulance plane was very comfortable. They really took care of us, cheered us up.

The video concludes with the boy's father saying, "Wherever you are the state is everywhere for your health." Then the voiceover says, "We started the transformation in health in the 112 emergency services and have achieved revolutionary novelties. It was a dream but has become a reality."[62]

The second video is about a pregnant woman who is carried to the hospital by an ambulance with a snow pallet. The video shows a village under snow where a young man starts telling the story of how his wife was brought to the hospital by a special snow ambulance in the city.

> Here in our lands winters are harsh. It starts to snow heavily all at once. The roads get blocked in one night. Recently my wife's labor pains started. I called 112 immediately. Regardless of winter and snow, the snow ambulance came all the way up to the village. They said they will take her to the hospital in the city. They had made a hospital in which everything was thought of beforehand. My child was born and then they took my wife to a private room. Later on, they brought us back to the village with the ambulance. I see who helps me in my hard times. I take actions seriously, not words. Always nation, always service, AKP.[63]

62 "Ak Parti Sağlık Reklam Filmi," posted anonymously, May 16, 2011, video, 0:44, https://www.youtube.com/watch?v=3qt6PQMND-I. (See appendix C.63 for the original)

63 "Sağlık Hizmeti AK Parti Reklam Filmi," posted anonymously, February 24, 2015, video, 0:44, https://www.youtube.com/watch?v=EwZOEISesNw. (See appendix C.64 for the original)

While he tells the story, the camera shows the young man walking in the snow, at the level of his knee. The second scene is at home, where his pregnant wife sits with their young son on a sofa with an uncomfortable face. Then the snow ambulance arrives in the village and takes the couple to hospital. The following scene is in the hospital room where a nurse brings the newborn to his mother and the father kisses the baby's forehead. Then we see the father in front of the ambulance shaking hands with the ambulance driver. The last scene shows the family together with the baby.

In both videos what is emphasized is that the new services provided to citizens by the AKP government have no equivalent, and those services have life-saving value. What has been underlined in both videos is that the people telling their experiences are surprised and appreciated of the new services provided. In one case, this leads to saving a young boy from losing his hand by not losing time by using an ambulance plane. And in the other case, a young woman is taken from her hard-to-reach village to the hospital by a specialized snow ambulance to give birth. The videos emphasize how these impossible-to-imagine novelties are implemented for the first time by the AKP.

4.2.3 *Introducing New Services*

Apart from new equipment such as plane ambulances, snow ambulances, and redesigned hospital rooms, new types of services introduced during the AKP governments are also presented in the discourses of the AKP. The practice that comes forward most is the family practitioner model, which is a significant element of the Health Transformation Program. The family practitioner model started as a pilot project in Bolu province and was later begun in all provinces in 2011.

The introduction of the family practitioner model is presented in the discourses of the government as a novelty that eases the ways that citizens receive health care services and simplifies their access to the health system. As with other novelties introduced, this practice is framed as an AKP product the main aim of which is to serve the people in a different way than its predecessors by providing them with what they deserve.

During an interview in 2003, Recep Akdağ described the family practitioner model in detail:

> As the Ministry of Health the issue that we prioritize the most in 2004 is establishing the Family Practitioner model. The doctors that now work as general practitioners will be working as family practitioners. Our citizens will use their free will to choose the doctor they want. They will tell the doctor, "you will be my family practitioner from now on and I want to be followed by you." and this doctor will earn more in proportion to the number of patients that are registered to him. As the patient is registered and followed regularly, the doctor will better know his patient more and the patient will trust the doctor. In this way, we will prevent waste in health care expenses. This will decrease the piling up of patients in hospitals. The family practitioner will refer his patient to a specialist when needed, and this specialist will add the necessary notes to the patient's file and send it back to the family practitioner. By starting in 2004, this model will hopefully be practiced all over the country during our government.[64]

Law No. 5258 regarding the Family Practitioner Pilot model was passed on 22.11.2004, and the pilot application of the model started in Düzce on 15.09.2005. By the end of 2010, the family practitioner model had started in all provinces in Turkey. The presentation of the model by Recep Akdağ in 2003 shows the aim of this model to provide a new approach to the provision of primary health care in particular but also health care services in general through directing patients to specialists with a referral system. This decreases the number of first applications done directly to hospitals and is a step that is claimed to ease the provision of health care.

Four years later, in the 2007 AKP Election Bulletin, the same practice was mentioned in the following way:

> We started the family practitioner model which is among the basic elements of a modern health approach. Nine million of our citizens are

64 *Türkiye Bülteni* 5 (2003): 41. (See appendix C.65 for the original.)

> making use of this practice, which is a big step for the future and is continuing successfully in 11 pilot provinces.[65]

In an article published in *Türkiye Bülteni* that summarizes developments in the health sector, the family practitioner model is also mentioned:

> We started the Family Practitioner model, which can be reached day and night by all family members. We made it possible for all our citizens to receive primary health care free of charge. With 20,500 family practitioners we are closely following the health problems of our people.[66]

In both statements the success of the government is underlined, as in the previously provided examples, through the number of doctors and patients. It is stressed that this practice is bringing the Turkish health system up to the standards of its contemporaries and allowing citizens an easy-to-reach, free primary health care service. As mentioned with respect to the other issues, this new practice is framed as a novelty introduced to ease peoples' lives and as an achievement implemented for the first time by the AKP. The statement of Recep Akdağ on health reform in general and on the family practitioner model in particular can be given as an example of this argument of the AKP that distinguishes itself from both its contemporaries and predecessors:

> Indeed, in the last 15 years in Turkey a lot of work has been done to reform or transform health. Especially with the work initiated during the Özal period, which were supported and framed by WB (World Bank) projects and credits, a lot of thoughts on change emerged. But as the governments were short-lived and were mostly coalition governments - and as mentioned before the mentality of those in power did not put the human at the center – it was difficult to realize these changes.[67]

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65 "AKP 2007 Seçim Beyannamesi," June 2007, 78. www.akparti.org. (See appendix C.157 for the original.)

66 *Türkiye Bülteni* 69 (2010): 28. (See appendix C.158 for the original.)

67 *Türkiye Bülteni* 5 (2003): 41. (See appendix C.66 for the original.)

4.2.4 *Technological Developments*

Services that make use of telecommunications and the internet in health care are also presented as steps that increase the quality of services and render services accessible to citizens at all times from wherever they are. The establishment of a call center dedicated to providing assistance and a center to which citizens can direct their complaints about health services occupies various different statements of the ministry. In an issue of *Türkiye Bülteni* where changes that took place in the health sector are emphasized it is stated that:

> The 184 SABIM communication line is at the service of all our citizens twenty-four hours a day, seven days to reply to all their questions related to health care service provision. With a communication line accessible through 185 telephone lines, it will also be of service to our citizens with SSK coverage, and will answer their questions, and help resolve their problems.[68]

In an issue of *Türkiye Bülteni* published before the 2007 parliamentary elections, usage of these call center services is mentioned with emphasis on its success in receiving numerous applications: "Additionally, the Health Information Communication Center (184 SABIM) has been established through which 90% of the problems of our citizens are resolved in 24 hours. This center handles 1 million queries every year."[69]

§ 4.3 The Discursive Emphasis on Patients' Rights

Patients' rights and the right of patients to choose the doctor and hospital from which they want to receive service are issues underlined in the discourses of the AKP. Patients' rights were introduced as a pilot project in early 2003 in Istanbul. This project aimed to systematically receive the complaints of patients regarding their experiences in hospitals. In the first Doctor's Day Speech

68 *Türkiye Bülteni* 22 (March 2005): 23. (See appendix C.159 for the original.)

69 "Ayrıca vatandaşlarımızın sorunlarının yüzde 90'ını 24 saat içinde neticelendirip çözen Sağlık Bilgi İletişim Merkezi (Alo 184 SABİM) kuruldu. Bu merkez her yıl 1 milyon başvuruyu sonuçlandırıyor." *Türkiye Bülteni* 47 (April 2007): 50.

delivered by the Minister of Health after the first election of the AKP in the November 2002 parliamentary elections, he presented the planned launch on the patients' rights issue in the following way:

> From now on we also want patients' rights to come to the fore during Doctor's Day. In this regard, we recently contacted the associations of patients' relatives. We chose Istanbul as a pilot province and set up special offices concerning patients' rights in some hospitals in Istanbul. We are developing a new model in these offices together not just with public officers but also with the responsible people in patients' relatives associations. We will soon put this into practice across the whole country in the coming days.[70]

Following this speech by Akdağ, 60 patients rights units were established in hospitals in 2004, and on 26 April 2005 a directive entitled "Directive on the Practices of Patients' Rights in Health Care Units"[71] was issued. On the establishment of patients' rights units in hospitals, Recep Akdağ made the following statement in May 2004:

> Until now, patients' rights units and boards were established in 60 hospitals attached to the Ministry of Health. Citizens can communicate the problems they face and their demands regarding the hospitals to these units. Complaints that are communicated to these units will be simultaneously monitored at the Ministry of Health headquarters. Given the work initiated and realized last year, patients' rights practices employed in European countries will be applied to the Turkish

70 Recep Akdağ'ın 13 Mart 2003 tarihli konuşması," March 13, 2003, https://www.tbmm.gov.tr/tutanaklar/TUTANAK/TBMM/d22/c007/tbmm22007045.pdf. (See appendix C.67 for the original.)

71 "Sağlık Tesislerinde Hasta Hakları Uygulamalarına ilişkin Yönerge," https://www.tbmm.gov.tr/komisyon/insanhaklari/belge/um_sagliktesislerindehastahaklari.pdf.

> health system, too, in coming years. In the patients' rights units, in addition to hospital personnel, the representatives of patients associations will work.[72]

This statement shows how patients' rights units were introduced as a practice to reach the standards of European countries and how health care service receivers are protected in case they have a complaint. Thus, a theme that is present in the discourses of the AKP whereby the government assures the protection of health care receivers from health care providers can be observed with respect to this issue as well. In a speech delivered by S. Demirel, vice chair of the Directorate General of Treatment Services of the Ministry of Health, in November 2004, this theme of protection of patients from health care providers can be seen:

> By 2004, 7000 applications have been made to patients' rights units in hospitals attached to the Ministry of Health in order to protect patients' rights and prevent the problems experienced in hospitals. The Ministry evaluated the applications made through the internet and in person, found 23 percent of the complaints of patients relevant, and asked the health personnel that were the subject of these complaints to defend themselves. Administrative investigations were initiated for 20 percent of these personnel, and when needed, pay deductions were made.[73]

Once again, the emphasis is on the government's promise to protect health care receivers, which was not possible until the AKP era, as emphasized in earlier examples discussed in this and the previous chapter. Serving citizens in a manner that was not possible before is underlined during the presentation of new practices. The possibility for patients to choose the doctors and hospitals from which they want to receive treatment is another issue highlighted in

72 "Vatandaş Hakkını Ararken Cesur Olmalı," *Zaman*, May 22, 2004. http://www.zaman.com.tr/gundem_saglik-bakani-akdag-vatandas-hakkini-ararken-cesur-olmali_50843.html. (See appendix C.68 for the original.)

73 "Bakanlık Hasta Şikayetlerini Haklı Buldu," *Zaman,* November 30, 2004, http://www.zaman.com.tr/gundem_bakanlik-hasta-sikayetlerini-hakli-buldu_116761.html. (See appendix C.69 for the original.)

AKP discourses as a practice was made possible by the priority of the AKP to serve the people in the way they deserve, which – it is claimed - was not the case until their arrival in power.

§ 4.4 Concluding Remarks

This chapter aimed at showing how the AKP presented the initiatives it took in health sector. The analysis of the presentation of the novelties by the AKP government which are discussed through issues such as increase in the number of doctors and auxilary health personnel, increase in the number of health units, reduction of bureaucratic procedures and introduction of new health equipment.

Like the issues mentioned in the Chapter 3 the presentation of the novelties by the AKP underlined their difference from the predeccors and the symbols of the "New Turkey." The portrayal of the difference underscored how the opponents of the reform wanted the country to lag behind while the AKP prioritized making the health system more efficient with the aim of serving the people. For instance the opposition to the change of law regarding the recruitment on foreign doctors was shown as an example of the divide between the AKP and the opponents, where the AKP aims to meet the "immediate needs" of the people, while the opponents were putting obstacles to that.

All in all, the portrayal of the novelties were materialization of the discourse of creation of a "New Turkey" that differs from the old one in terms of the prioritization of the needs of the people that were disregarded by the elites of the pre-AKP period. The divide between both the new and old Turkeys and the underscoring of the opposition among the health service providers and health service receivers were highlighted by foregrounding the unprecedent provision of technology, service and legal arrangements in the health sector.

5

Health Reform in Pro-Government Media Discourse: Pitting Providers against Receivers

The previous two chapters showed how the discourses of the government and the Ministry of Health portrayed the Health Transformation Program as the materialization of a "New Turkey" through publications of the AKP, election bulletins, governmental programs and public speeches leading up to elections. This chapter looks at how the newspapers that position themselves as politically close to the government portrayed and presented the health sector agenda of the government. The chapter is based on a scan of two major pro-government newspapers of the period, *Zaman*[1] and *Yeni Şafak*, between 2002-2011. These two dailies were scanned for news articles and columns on health policy changes in particular and the Turkish health sector in general.

The aim of the chapter is to show how the pro-government media portrayal of the health sector complemented a broader discursive narrative of the

1 It should be noted that the 17-25 December 2013 corruption investigations targeting the government changed the relationship within AKP circles and the Gülen movement changed dramatically. Following that period Zaman which had an organic link with the Gülen movement can hardly be defined as a pro-government newspaper and from 4th March 2016 the newspaper was run by an appointed trustee by Istanbul 6th Criminal Court of Peace. Following the 15th July 2016 coup attempt it was closed down with a statutory decree issued by the government within the state of emergency authorization on 27 July 2016.

government on health. This portrayal positions the government determined to end victimizations caused by the pre-AKP era health care system, presents changes introduced to the health care system by the AKP as unprecedented developments, and depicts opponents of the reform - namely doctors- as driven by self-interest.

As discussed in previous chapters, health-care providers and receivers emerge as two opposing sides in the AKP's discourse on health care reform. As this chapter will demonstrate, this opposition between providers and receivers was also central to the pro-government media's representation of health care reform. In other words, the pro-government media consistently pit providers against receivers. News articles portray doctors a self-interest driven and present the AKP as a protector of citizens-patients from health personnel and institutional practices that victimized the patients in the pre-AKP health system.

The chapter is organized into five parts. The first concerns the portrayal of the pre-AKP health care system which underscored how it victimized people. The second part concerns how the AKP is portrayed as an actor determined to end corruption in the health care system through the Health Transformation Program. The third part focuses on the portrayal of doctors as self-interest driven actors. The fourth part concerns how anti-Health Transformation Program actors are portrayed, and the fifth focuses on the celebration of the novelties of the health-care system following the Health Transformation Program in the media.

§ 5.1 Portraying the Pre-AKP Health System: A System that Victimizes the People

Especially in the first half of the 2002-2011 period there are a significant number of news articles in *Zaman* and *Yeni Şafak* newspapers focusing on stories about people encountering difficulties with the health system resulting in their becoming victims. At times, these resulted in permanent health problems or death. This subsection presents some of those articles and discuss how these stories are presented, how these difficulties are explained, and what they present as the source of problem.

This category of articles is significant as they clarify how the pro-government media makes use of such articles to justify transformations that are proposed for the health system. By saying this I neither dispute the truth of the stories nor deny the structural problems that they are concerned with (such as absence of ambulances and health personnel), but I argue that those stories also have value as justification for structural changes to the existing health system.

The stories can be divided into three categories. In the first category are articles about patients not released from hospitals even though their treatment was complete because they could not pay their bill. In some cases, the detained patients were children or babies, and the story was told by the parents. In most cases, one day after the publication of these articles another article about Recep Akdağ concerning that particular case is published, ordering the immediate release of the patient in question.

A news article entitled "Despite the Order of the Minister of Health, the Patient was not Released for 3 Days"[2] was about a five-year-old child who was not released from the hospital after a surgery as the parents could not pay the bill.[3]

As discussed in Chapter 3, the first circular published by the Ministry of Health of the 58th Government on 26 November 2002 concerned the discharge of patients. In this circular, which was sent to the governors' offices of all provinces in Turkey, Recep Akdağ requested that "In no health institutions patients, mothers and babies should be kept detained with the motive of non-payment of hospital expenses."[4] This circular is emphasized in the article twice.

2 "Sağlık Bakanı'nın talimatına rağmen hasta, üç gün rehin kaldı," *Zaman*, December 1, 2002. http://arsiv.zaman.com.tr//2002/12/01/haberler/h9.htm.

3 The manager of the hospital states that as the family of the child did not present their Green Card before the surgery they had no option but to invoice them.

4 "Sağlık Bakanı Recep Akdağ, ilk genelgesinde sağlık kuruluşlarından hastane masrafları ödenmediği gerekçesiyle hastaların, bebek ve annelerin rehin tutulmamasını istedi." "Hastalar Rehin Tutulmayacak," *Zaman*, November 27, 2002. http://arsiv.ntv.com.tr/news/189894.asp 27th November 2002.

As in similar articles in this category, the emphasis is on patients who were not released from hospitals suffering from practices that belong to the past. The foremost responsibility of the new minister, the articles emphasized, was to bring an end to this unequal treatment of patients. That the circular on the discharge of patients was the first of the ministry is significant in understanding the emphasis placed by the Justice and Development Party on universal access to health services and its discursive claim to end the victimizations of the pre-AKP system. As this chapter will demonstrate, through news articles concerning specific cases, the pro-government media contributed to and reinforced the AKP's discourse on detained patients.

The second most encountered type of news article are those about people suffering from the organizational or structural problems of SSK hospitals. These stories are especially common from late 2002 until the transfer of SSK hospitals to the Ministry of Health. The problems encountered due to structural obstacles related to the fragmented social security system (such as not being able to receive a service from a certain hospital or not being able to buy a prescribed medicine because access to that medicine is only provided through one channel) can be discussed under this category. These news articles gradually decrease in number following the transfer of SSK hospitals to the Ministry of Health and the enactment of the Law on Social Security and General Health Insurance (SSGSS) in April 2008.

The articles on SSK hospitals focus mainly on the lack of personnel and equipment and the overload of patients. When interviewed, hospital managers state that they try to provide service with the present equipment and personnel. The article "Little Buse had a Seizure while Waiting in the Queue for Medicine[5]" tells how a five-year-old child waited five hours to get her prescription filled at an SSK hospital pharmacy.[6] This story emphasizes the hospital's inability to provide sufficient services to the patients present. In the article "The

5 "Annesiyle 5 saat ilaç kuyruğunda bekleyen küçük Buse havale geçirdi." *Zaman*, January 25, 2003. http://arsiv.zaman.com.tr//2003/01/25/icanadolu/h7.htm last access 13.08.14.

6 Before the transfer of SSK hospitals to the Ministry of Health the patients with the SSK scheme were able to buy their medicines only from the pharmacies of the hospitals or from the pharmacies that have a protocol with SSK.

Lack of MRI Facility Creates Problems in a SSK Hospital,"[7] SSK Çorum Hospital is revealed to have no MRI facility despite the fact that there are 60 thousand patients treated there each month. Additionally, it is stated that due to the lack of a radiologist, the existing ultrasound facility is not being used. In the article "There are not enough doctors in SSK,"[8] the insufficient number of health personnel in Gebze's SSK hospital is mentioned. In addition to children, the elderly are held up as visible victims of the health system. The article "Patients with the SSK scheme wait for hours for their health certificate"[9] highlights the hours-long wait for a health certificate in Bursa SSK hospital. The emphasis is on a lack of personnel and buildings, which were the reasons for the long queues.

These news articles portray SSK hospitals as structurally-insufficient institutions, but the emphasis, unlike in the cases of detained patients mentioned above, is not on the initiative of hospital personnel but rather the inability of managers to improve the situation as minimum requirements are not met by the SSK. These articles form the basis for the opinion that the social security system in general is fragmented and specifically the SSK social security scheme and its components need transformation.

The third category of articles are those that focus on the lack of health personnel - especially doctors - in rural areas in eastern and southeastern provinces. The articles describe cases in which patients suffered severely or died either because there was no health unit where they lived or, even if a unit existed, no health personnel staffed it and the patients had to travel.

At the time when the law on compulsory service (*zorunlu hizmet*) was being discussed, there were articles in newspapers showing insufficient number of doctors in certain provinces, especially in Eastern and Southeastern Turkey. In the article "Distribution of Doctors is Unbalanced" the places with the

7 "SSK Hastanesi'nde tomografi cihazı olmaması sıkıntıya yol açıyor." *Zaman*, March 30, 2003, http://arsiv.zaman.com.tr//2003/03/30/icanadolu/h10.htm.

8 "SSK Hastanesinde Doktor Sıkıntısı Yaşanıyor," *Zaman*, January 9, 2003. http://arsiv.zaman.com.tr//2003/01/09/marmara/h11.htm.

9 "SSK'lılar Sağlık Karnesi için Saatlerce Kuyrukta Bekliyor." *Zaman*, December 25, 2002. http://arsiv.zaman.com.tr//2002/12/25/marmara/h9.htm.

highest number of patients per doctor were indicated as Ardahan, Tunceli, Bayburt, Kilis, Hakkari, Iğdır, Şırnak, Siirt, Bingöl and Gümüşhane.[10] It is stressed that the people in these provinces are helpless and the lack of health personnel result in deaths.

The case of 6 patients dying in Hakkari province was a highly covered news item in early 2004.[11] Six patients with kidney failure died in one month due to a lack of doctors with a specialization in dialysis. Even though one of the undersecretaries of the Ministry of Health stated that the deaths of these patients were not directly related to the absence of health personnel, a doctor with a specialization in dialysis was appointed to Hakkari immediately and it was stated that legal regulations to improve the personal benefits for doctors working in eastern and southeastern provinces would soon be presented to parliament. The appointment of doctors to eastern provinces was an important item on the agenda of the Ministry of Health in the first half of the 2002-2011 period. The presence of this issue in the media will be covered in the subsection where the portrayal of doctors will be discussed.

The portrayal of "victims of the system" in the news articles provides a broad representation of the pre-AKP period. The health system present when the AKP came to power is depicted as one where access was difficult, coverage was limited, and geographic disparities were apparent. As a consequence - it is implied - children, babies, pregnant women, elderly - the most vulnerable parts of the population - suffered severe consequences such as loss of life, not receiving services or receiving the services belatedly.

§ 5.2 Portraying Health Reform as a Fight against Corruption

Articles in newspapers related to corruption can be examined in two categories. First are individual corruption cases related to a single hospital or doctor that were discovered coincidentally. Following these articles, those responsible

10 "Doktor Dağılımı Dengesiz," *Yeni Şafak,* March 14, 2006.

11 "Hakkari'de Doktorsuzluk Yüzünden 6. Hasata da Öldü!..." April 22, 2004. http://www.habervitrini.com/gundem/hakkaride-doktorsuzluk-yuzunden-6-hasta-da-oldu-127372/. "Haydi doktorlar doğuya!" *Yeni Şafak,* April 25, 2004. http://www.yenisafak.com.tr/arsiv/2004/nisan/25/g03.html.

for the corruption are removed from their place of work, and in some cases the Ministry of Health or Ministry of Labor and Social Security made statements regarding their stance on corruption.

A significant number of the individual cases of corruption concern additional payments referred to as "bıçak parası" (knife money) in Turkish, referring to a cash payment to a surgeon prior to an operation. In these articles, the main focus is that patients are disadvantaged by this "institutionalized," "normalized" payment that doctors see as normal. The emphasis is on how the AKP stands against this practice, responds to it with legal means, and treats it as a crime.

In the article "Report Those who Ask for Additional payment"[12] a statement by Akdağ is quoted where he stresses the importance of citizens' reactions to demands for additional payments by surgeons; only through this can the ministry combat this issue. The prioritization of this issue on the agenda of the government is also emphasized in another article about the establishment of a call center specifically to handle complaints for additional payments. Akdağ stated that:

> We see the money interaction between doctor and patient as very problematic and we are determined to put an end to it. Citizens should be aware of the situation and should not feel they have to make additional payments. If they encounter such a demand they should immediately contact the administration of the hospital, the governor of the province, or the Ministry of Health.[13]

Some articles on the "bıçak parası" issue focus on individual cases where patients reported the problem and summarize the events leading up to the complaints, giving details about the legal proceedings against the doctors in question. Two articles on the same issue concern a case where the patient who was asked to make an additional payment refused and then reported the case to

12 'Bıçak Parası İsteyeni Mutlaka Şikayet Edin,' *Zaman,* September 14, 2003. http://arsiv.zaman.com.tr/2003/09/14/haberler/h11.htm.

13 "Bıçak Parası'na 444'lü Hat geliyor," *Zaman,* May 24, 2003, http://arsiv.zaman.com.tr//2003/05/24/haberler/h13.htm. (See Appendix C.183 for the original.)

the public prosecutor (Cumhuriyet Savcılığı). The doctor who asked for the additional payment was arrested and taken into custody. The punishment demanded by the magistrate was ten years imprisonment, but the doctor's lawyer stated that the payment requested was only to cover the costs of the operation.[14]

In an article entitled "The Doctor Got Caught Red-handed, Now She is Afraid to Go to the Hospital,"[15] a patient tells her own story emphasizing that she did not wish to make a complaint, she could not pay and she urgently needed an operation. It was her last resort and she did not know that the doctor would be taken into custody. She adds that she cannot go to the hospital now, as she is concerned about the reactions of the doctor's colleagues.

Taken together with other articles in the same newspaper about "bıçak parası," this case portrays the attitude of patients that needed to change in order to combat the corruption cases Akdağ describes. What is communicated with this article is that even though the Ministry of Health constantly announces that patients are not to make these payments and that asking for them is a crime, patients are reluctant to make complaints and those who do later feel guilty and feel a need to justify their complaints. It is implied that patients have internalized their helplessness when faced with such a demand, particularly given the unjust practices of the "pre-AKP health system" that render them victims.

The second category is a significant corruption case –related to SSK. This case was covered in detail by *Zaman* newspaper. The name of the operation conducted against the corruption case is "Neşter," a judicial process that took place in the State Security Court (*Devlet Güvenlik Mahkemesi*). This operation concerned the corruption related to the purchase of medical supplies for the SSK and covered the period from 1992 until early 2003. Conducted by the magistrate of Ankara, this corruption case was investigated nationally, leading

14 "Bıçak Parası Aldığı için Tutuklanan Doktor On Yıl Hapisle Yargılanacak," *Zaman*, August 21, 2005. http://www.zaman.com.tr/gundem_bicak-parasi-aldigi-icin-tutuklanan-doktor-10-yil-hapisle-yargilanacak_203678.html.

15 "Doktora Suçüstü Yaptırdı Korkudan Hastaneye Gidemiyor," *Zaman*, August 24, 2005. http://www.zaman.com.tr/gundem_doktora-sucustu-yaptirdi-korkudan-hastaneye-gidemiyor_204524.html.

to 32 arrests. There was an estimated loss to the state of 4 billion dollars. The steps of this operation were widely covered with follow-up articles.

This series of articles on the Neşter operation was part of the justification for transferring SSK hospitals to the Ministry of Health, explaining how, as in many areas of governance, the purchase of medical materials was also vulnerable to abuse and corruption.

The majority of these articles on the Neşter Operation describe the technical details of the case and name the accused bureaucrats, doctors, and businessmen. Towards the end of the case the articles became more discursive about the structural problems that led to this corruption and the structural consequences of the case.

The investigation started before the first AKP government in early 2002. It involved SSK bureaucrats, owners of companies that import medical equipment, and doctors. The equipment in question was used in cardiology operations, including catheters and stents. The doctors involved were accused of declaring more material than they actually used and reusing some surgical items for one-time use on multiple patients. The firms that import these materials are also accused of establishing cartels and selling the equipment higher than market prices.

For such purchases, SSK authorities used a bid process rather than a protocol method which led to cooperation among importers to sell the medical equipment at a higher price. These firms established shell companies abroad in order to increase prices.[16] Money transfers among doctors, bureaucrats, and the businessmen were documented.[17] The prosecutor of the State Security Court (Devlet Güvenlik Mahkemesi or DGM) sued more than 100 people related to this corruption case.[18] It is stated that the social security deficit decreased from 14 to 13 quadrillion after the investigation began, which is

16 "10 Firma SSK'da Kartel Oluşturmuş," *Zaman,* February 10, 2003. http://arsiv.zaman.com.tr//2003/02/10/haberler/h24.htm.

17 "Neşter Operasyonu Sanıkları Savcılığa Sevk Edildi, DGM Bankaları Uyaracak," *Zaman,* 01.05.2003 http://arsiv.zaman.com.tr//2003/05/01/haberler/h6.htm.

18 "Neşter Operasyonu'nda 100'den fazla Sanığa Dava Açılacak." *Zaman,* February 25, 2003. http://arsiv.zaman.com.tr//2003/02/25/haberler/h7.htm.

claimed to be directly related to Neşter.[19] Out of 59 suspects, 9 were arrested and put on trial with the magistrate demanding 5 to 45 years imprisonment. They were accused of setting up a benefits-oriented criminal organization. It was claimed that the same form of corruption was present in Bağ-Kur where the use of stents fell by one quarter compared to prior to the operation.[20] This operation was based on evidence that SSK resource funds were misused and corrupted.

The articles that describe the events strengthened AKP arguments about the need to transfer SSK hospitals to the Ministry of Health and about the structural problems of a fragmented social security system that had direct implications for the provision of health services. The vulnerability of the SSK in particular and other social security schemes in general to abuse due to a lack of control mechanisms was another point emphasized in these articles. The statement of the magistrate of Neşter exemplified how this operation is seen as a concrete example of the structural problems of the Turkish social security system: "With this investigation it became possible to observe the problems of the Turkish health and social security systems and how these problems brought the systems to the point of bankruptcy."[21]

Despite the solid basis of the accusations of in the Neşter case, at the end of the trial not all those charged with corruption were sentenced. Some accusations against businessmen surpassed the statute of limitations, but some doctors and other responsible employees in the hospitals were sentenced.[22] While the case was presented as an opportunity to draw attention to and end SSK corruption in particular and the problems of the social security system in

19 "Neşter Operasyonu'nda 100'den fazla Sanığa Dava Açılacak," *Zaman,* February 25, 2003. http://arsiv.zaman.com.tr//2003/02/25/haberler/h7.htm.

20 "Neşter Operasyonu Davası Açıldı 59 Sanık Hakkında 45 Yıla Kadar Hapis İsteniyor." *Zaman,* February 22, 2003. http://arsiv.zaman.com.tr//2003/05/22/haberler/butun.htm.

21 "Bu soruşturmayla Türkiye'de sağlık ve sosyal güvenlik sisteminin içinde bulunduğu sorunlar ile bu sorunların, sistemleri iflas etme noktasına getirişini gözlemlemek imkanı doğmuştur. Tuz kokmuş, dağ tükenmiştir." "Neşter Operasyonu Davası Açıldı 59 Sanık Hakkında 45 Yıla Kadar Hapis İsteniyor." *Zaman,* May 22, 2003. http://arsiv.zaman.com.tr//2003/05/22/haberler/butun.htm.

22 "Neşter Davasında Karar Çıktı." *Zaman,* December 2, 2011. http://www.zaman.com.tr/gundem_nester-davasinda-karar-cikti_1209536.html.

general, the final decisions in the case did not bring about structural change or prevent such corruption in the social security system as no company owners were sentenced.

§ 5.3 Portraying Doctors as Self-Interest Driven Actors

The articles portray doctors as a professional group who prioritize their own interests rather than patients in the practice of the profession. These articles can be examined in two categories. Firstly, some articles focus on the income-oriented choices of doctors and the internal regulations of hospitals. The second group are about the lack of doctors in eastern and southeastern provinces due to the unwillingness of doctors to work in those places.

Doctors as a professional group are described as people whose main objective is not to serve the people but rather to focus on their own material interests. In line with this general description, the following representations and claims prevail in the news articles: the people are deprived of the service they deserve as a consequence of doctors' choices and the medical profession itself is transformed into a tool to abuse the people's essential health service needs. These themes can be observed in the following articles, the first of which concerns the case of an institution (a university hospital) making a profit-oriented decision.

The article entitled "Being examined by a Professor Costs 50 Million More"[23] summarizes a practice introduced by the Istanbul University Faculty of Medicine. According to a notice published by the dean, patients wishing to be examined by a professor or associate professor would need to pay an extra sum of between 50-65 million lire.[24] This is justified by the administration as a means to increase income for the department. However, department members stated that they were not informed where this additional income would be channeled. Patients prefer to be examined by doctors with academic titles and

23 "Profesöre Muayene Olmak 50 Milyon Daha Pahalı," *Zaman,* March 16, 2003. http://arsiv.zaman.com.tr/2003/03/16/haberler/h1.htm.

24 As of 1 January 2005 Turkish Lira was revaluated and six zeroes were dropped from the currency. Thus 50 and 65 millions referred in this article equal to 50 and 56 turkish lire.

were disappointed by this new practice, calling it a "professor tariff." Additionally, the Ministry of Finance General Directorate of Budget and Financial Control (Maliye Bakanlığı Bütçe ve Mali Kontrol Genel Müdürlüğü) stated that this practice is not lawful as members of the department are only allowed to examine patients for a different tariff outside of working hours. The decision made by the hospital was declared in the article to be unlawful and unacceptable by the responsible unit of the Finance Ministry. Thus, the government did not approve the "profit-oriented" practice of the hospital.

Declarations by the Minister of Health about the practices of some doctors can be considered as a certain way of portraying the profession. In such declarations, which will be analyzed further in the following subsections, the ministry and the government's role is defined as to protect patients from practices that victimize them. As in the previous article, an article entitled "Akdağ: Report the Doctors who give business cards to the Governors"[25] states that the number of private offices of doctors are decreasing as payments to doctors who work only in public hospitals increased[26] hence, it is unacceptable for a doctor to refuse to examine a patient in a hospital. His emphasis was on the protection of patients, as mentioned above, and he concludes his statement accordingly: "No one can show another work address than the hospital he works in. If a doctor gives you his business card, please make a complaint to the governor."[27]

An article entitled "Doctors have less income than those on minimum wage!"[28] describes the statement of the Adana Revenue Office (Defterdarlık)

25 "Akdağ: Kartvizit Veren Doktorları Valilere Bildirin," *Zaman,* August 21, 2005. http://www.zaman.com.tr/gundem_akdag-kartvizit-veren-doktorlari-valilere-bildirin_203685.html.

26 Here Akdağ refers to the performance based payments before the full day working regulation.

27 "Hiç kimse benim vatandaşıma gittiği hastaneden başka bir adres gösteremez. Size hastanelerde kartını veren doktorları valimize bildirin." "Akdağ: Kartvizit Veren Doktorları Valilere Bildirin," *Zaman,* August 21 2005. http://www.zaman.com.tr/gundem_akdag-kartvizit-veren-doktorlari-valilere-bildirin_203685.html.

28 "Doktor Asgari Ücretliden Daha az Para Kazanıyormuş!" *Zaman,* March 11, 2004. http://www.zaman.com.tr/gundem_doktor-asgari-ucretliden-az-para-kazaniyormus_25054.html.

about the self-declared taxable income of doctors in Adana province. According to revenue office records, the annual declared income of doctors was 1,188 million lire,[29] which is less than minimal wage. When evaluated on the basis of declared income, the medical profession ranks among the least income-generating professions. The head of Adana Provincial Revenue office declared, following the release of figures, that "we prefer that doctors who practice such a sacred profession declare their income realistically rather than look for ways to pay less tax."[30] The last article related to this sub-theme shows the income-oriented professional choices of doctors, but on a larger scale.

An article entitled "When Private Hospitals Proposed High Salaries 3 000 doctors Resigned From State Jobs"[31] stated that 3,274 doctors resigned from public hospitals to start working in private hospitals. The article is based on data provided by Türk-Sağlık Sen, a health sector union known for its proximity to the nationalist right. According to the article, when the salaries of doctors in private hospitals went up to 15-20 thousand lire a month, it became harder for public hospitals to encourage doctors to continue working there. In Turkey, there were 108,000 doctors, 63,000 of which work for the Ministry of Health. And while the ratio of patients per doctor is 653, for doctors working for the Ministry of Health it is 1,104. This difference, the article shows, is a result of the inclination of doctors to work in private hospitals.

In all articles, doctors as a professional group are portrayed as people who prioritize their own interests rather than serving the people, acting contrary to the ethos of their profession which, as defined in the last quote, is sacred. Patients are shown as victims of this structural, deeply-rooted practice among doctors. The ministry and the government, on the other hand, position themselves as the actor bringing novelty to the health sector, introducing its own

29 This when converted to the post-revaluation currency is 1,818 Turkish Lire.

30 "Doktorluk gibi kutsal bir mesleği icra edenlerin devlete daha az vergi ödemenin yollarını aramak yerine gerçekçi rakamlar sunmalarını isteriz." "Doktor Asgari Ücretliden Daha az Para Kazanıyormuş!" *Zaman,* March 11, 2004. http://www.zaman.com.tr/gundem_doktor-asgari-ucretliden-az-para-kazaniyormus_25054.html.

31 "Özel Hastaneler Yüksek Maaş Verince 3bin Doktor Devletten Ayrıldı," *Zaman,* March 15, 2009. http://www.zaman.com.tr/gundem_ozel-hastaneler-yuksek-maas-verince-3-bin-doktor-devletten-ayrildi_825544.html.

ethos of service to the people, and making medical professionals serve the people, too.

The second category of articles focus on the issue of the insufficient number of doctors in eastern and southeastern provinces as a consequence of the unwillingness of doctors to work there. The emphasis is that doctors, despite material incentives introduced by the Ministry of Health, do not choose to work in these provinces. Articles published after the introduction of compulsory service for doctors focus instead on how doctors try to find ways of not going to where they are appointed.

In an article entitled "Even Doubled Salaries could not Persuade Doctors to Go to the East,"[32] the practices of the Ministry of Health to encourage doctors to go to eastern provinces is summarized. Doctors are offered approximately a threefold higher salary than what is paid in western provinces; additionally they would be able to receive shares of revolving funds. At the time this article was written, compulsory service for general practitioners had been abolished, and instead, a voluntary, contract-based employment model was in place for eastern and southeastern provinces. However, article stated that there were 940 vacant posts for specialists, to which only 177 specialist doctors applied. As for general practitioners, there were 413 applications for 2545 vacant posts. It is emphasized in the article that doctors do not prefer to work in the eastern and southeastern provinces as, unlike in western provinces, there is no possibility to work in a private health unit or hospital after standard working hours. What is underlined, as mentioned earlier, is that doctors choose to work in their own interest rather than to do what is ethically and professionally required.

This choice of doctors is portrayed as the only reason behind the high number of patients per doctor in eastern and southeastern provinces. In an

32 "İki Katı Maaş Bile Doktorları Doğuya Gitmeye İkna Edemedi," *Zaman,* April 14, 2004. http://www.zaman.com.tr/gundem_iki-kati-maas-bile-doktorlari-dogu-ya-gitmeye-ikna-etmedi_36760.html.

article entitled "Akdağ: In the Underdeveloped Regions we are short of Doctors,"[33] a statement of Recep Akdağ's focuses on the unwillingness of doctors to go to eastern provinces despite the high salaries offered to them. In an article published on the eve of the reintroduction of compulsory service for doctors, the statement of the chair of TTB (Turkish Medical Association) Gencay Gürsoy, is cited in an article titled "A Strange Defense from Gürsoy."[34] Gürsoy's statement focuses on infrastructural problems, such the lack of accommodations, in eastern and southeastern provinces and states that if those problems are resolved, there would surely be doctors who would respond to the call to fill vacant posts. The title of the article suggests that the reasons given by Gürsoy are illegitimate; rather, they are excuses for not going to the eastern provinces.

Compulsory service was reintroduced in July 2005 and included both general practitioners and specialist doctors. It required them to work for between 300 and 600 days in the region. The law impacted doctors that had never worked in public service before and those who graduated after the law was passed. Thus, not all doctors in Turkey were included in this compulsory scheme. The Ministry of Health was still, after the passage of the law, trying to understand the lack of doctors in eastern and southeastern provinces. In an article entitled "Follow-up is Introduced for Those Who Do not Perform Compulsory Service"[35] it is emphasized that the Ministry of Health was seeking to understand the reasons for the unwillingness of doctors to go to eastern provinces. Following the regulation introduced in July 2005, the Ministry of Health made monthly appointments to eastern and southeastern provinces and decided to make regular visits to the region.

33 "Akdağ: Az Gelişmiş Bölgelerde Hekim Güçlüğü Çekiyoruz." *Zaman,* November 21, 2005. http://www.zaman.com.tr/gundem_akdag-az-gelismis-bolgelerde-hekim-guclugu-cekiyoruz_231159.html.

34 "Gürsoy'dan Garip Savunma," *Yeni Şafak*, March 14, 2006.

35 "Zorunlu Hizmete Gitmeyen Doktorlara Yakın Takip Geliyor," *Zaman,* June 11, 2006. http://www.zaman.com.tr/gundem_zorunlu-hizmete-gitmeyen-doktorlara-yakin-takip-geliyor_292736.html.

The Ministry of Health is portrayed in the articles as an actor taking measures to ensure that doctors work in eastern and southeastern provinces. However, doctors are portrayed as resisting their appointed posts. An article entitled "They Arranged a Pseudo-Marriage to avoid Compulsory Service"[36] outlines a case where doctors entered a false marriage to avoid going to where they are appointed, and the preventive measures of the Ministry of Health to avoid such attempts. The article recounts the case of a female doctor who married a doctor working in Istanbul after being appointed to Bingöl. This false marriage was discovered after photos were uncovered of an unofficial marriage of the same doctor, and an investigation by the magistrate was initiated. The human resources manager of the ministry declared that such attempts had decreased compared to previous years but that the ministry cannot take any more preventive measure other than asking for documentation of marital status to verify the veracity of marriages. The measures taken by the Ministry of Health to decrease the discrepancy between eastern and western provinces in terms of the number of doctors suggest that it could only be resolved through a compulsory service system and that doctors are even trying to bypass this system. The position of doctors in these cases is portrayed being ethically paradoxical to a service orientation and to what the government is trying to achieve in terms of creating more equal access to the health system. It does not - it is claimed - correspond to the ethos of the medical profession.

§ 5.4 Dismissing the Anti-Health Transformation Program Actors and Discourses

As will be discussed in detail in Chapter 6, following the announcement of the Health Transformation Program by the government, strikes and demonstrations were organized by the TTB with the collaboration of the SES and local medical chambers, mainly of the provinces of Istanbul and Ankara. In this subsection, the discussion is limited to how pro-media government covered

36 "Mecburi Hizmete Gitmemek için Sahte Evlilik Yaptılar," *Zaman*, September 21, 2007. http://www.zaman.com.tr/gundem_mecburi-hizmete-gitmemek-icin-sahte-evlilik-yaptilar_591246.html.

these protests. Articles that cover the major strikes are examined in order to look at what themes were foregrounded in the pro-government media while presenting these events.

For strikes and demonstrations organized nationally by the TTB, the emphasis of the articles is that the majority of doctors did not participate. An article entitled "In the Doctor Demonstration There were More Police than Doctors"[37] states that a demonstration organized by the Istanbul Medical Chamber about the increase of salaries attracted greater interest among the media and police than among doctors.

The stress on the lack of participation in the strikes is more evident as participation in the strikes – during which strikes were not providing health care services - was mentioned to be contrary to the professional ethics of doctors. The statement of Recep Akdağ regarding doctor's lack of participation in the demonstrations is as an example: "Throughout the country doctors did not participate much in the strikes. This is a consequence of doctors' sensibilities and awareness of the importance of health care services."[38]

Before the strike of 24 December 2003, an article entitled "Doctors of the TTB are Going on Strike Again on 24 December" stated that participation in the strike on 5 November 2003 was lower than expected and that only private clinics had benefited from the strike. Ministry of Health hospitals did not join the strike, but some SSK hospitals took part.[39] Following the strike on 24 December 2003, in an article entitled "Doctor members of parliament of AKP Made a Call for Dialogue to Doctors of TTB," it is stated that nowhere in the country was there strong participation in the strike, and in some provinces no doctors participated at all.[40] The title of the article "Medical Chambers Called

37 "Doktorların Eyleminde Doktordan çok Polis Vardı," *Zaman,* January 15, 2003. http://arsiv.zaman.com.tr//2003/01/15/marmara/h3.htm.

38 "Tabip Odası: Bu Bir Uyarı Eylemi; Bakan Akdağ: Demokratik Hak," *Zaman,* November 6, 2003. http://arsiv.zaman.com.tr//2003/11/06/haberler/h10.htm.

39 "TTB'li Doktorlar 24 Aralık'ta Yeniden Sahneye Çıkıyor," *Zaman,* December 23, 2003. http://arsiv.zaman.com.tr/2003/12/23/haberler/h13.htm.

40 "AK Partili Doktor Vekiller İş Bırakan TTB'li Doktorlara Diyalog Çağrısı Yaptı," *Zaman,* December 25, 2003. http://arsiv.zaman.com.tr/2003/12/25/haberler/h7.htm.

it Strike Doctors Called it Duty"[41] itself distinguishes between doctors who decided to go on strike and those who do not agree with them. It is additionally stressed that health professionals did not participate in high numbers. As can be seen from the titles of the articles mentioned previously in this subsection, the strikes also suggest a division between "TTB doctors" and other doctors. According to the articles, while TTB doctors, who were low in number, participated in the strikes, and the majority of doctors are portrayed as prioritizing "their duties " - i.e. providing health services to patients.

While there is emphasis on how the TTB's national calls to strike did not receive a high response from doctors, there is even stronger emphasis on how the strikes will negatively impact the lives of citizens. This second theme especially arises in articles published before the strikes. In the articles published following the strikes, the emphasis is on how strikes made it difficult for patients to receive services. Stories about patients who could not receive services constituted a large portion of the articles. Furthermore, doctors who participated in strikes are portrayed as having directly, negatively impacted the lives of these patients.

The titles of the articles that appear before the strikes have a discouraging tone: "Doctors are on strike, so do not get sick today"[42] and "Doctors are on strike, so do not go to the hospital tomorrow"[43] are titles of articles published before the strike on 5 November 2003. "Health Services will slow down for 2 days"[44] is also typical, and all these titles characterize the strikes as obstacles to receiving services.

The statements of Recep Akdağ and Ministry of Health officials appear in articles published before the strikes. In these statements, the legality of the strike is questioned and doctors who participate are accused of trespassing the

41 "Tabip Odaları Grev Doktorlar Grev Dedi," *Zaman,* March 15, 2007. http://www.zaman.com.tr/newsDetail_openPrintPage.action?newsId=513219.

42 "Doktorlar Grevde Bugün Sakın ola Hastalanmayın," *Zaman,* November 5, 2003. http://arsiv.zaman.com.tr//2003/11/05/haberler/h7.htm.

43 Doktorlar Grev Yapıyor Yarın hastaneye Gitmeyin," *Zaman,* November 4, 2003. http://arsiv.zaman.com.tr/2003/11/04/haberler/h9.htm.

44 "Sağlık Hizmetleri İki Gün Aksayacak," *Zaman,* March 10, 2004. http://www.zaman.com.tr/gundem_saglik-hizmetleri-iki-gun-aksayacak_24683.html.

ethical codes of their profession. Additionally, it is emphasized that doctors who participate in the strike would be subject to administrative investigations.

A common theme that emerged in the previous subsections is that the health reforms of the AKP government are presented as a rupture from previous health care practices with an emphasis on increased access, equality, and the service of citizens in a way that prevents them from being vulnerable to the structural inconveniences of the health care system that is handed over to the AKP government from the previous governments. From this perspective, the strikes of doctors in particular and the political stance of the TTB in general are presented as opposed to the AKP's aim to provide an equal, accessible health care system that serves the people rather than professional interests. The Ministry of Health, in addition to stressing that they will start legal proceedings against striking doctors, also emphasized that the opposition to the health care policies of the AKP did not want the health care system to improve either in terms of quality of service or accessibility to more citizens.

In the article entitled "Akdağ: Investigations will start into doctors who strike,"[45] Recep Akdağ states that

> being a health professional means serving the people. I also worked as a doctor under hard conditions but never imagined striking. In a public institution belonging to my ministry, whoever - for whatever reason - does not provide proper service to citizens will face an administrative investigation. Neither the Turkish people nor most Turkish doctors can accept such a situation.[46]

The strike is defined as an obstacle to the delivery of services.

In the same article, the stance of the TTB is presented as an archaic ideological heritage that is completely opposed to the novelties introduced by the AKP. The strike in question was organized to protest government health poli-

45 "Akdağ: İş Bırakacak Doktorlar Hakkında Soruşturma Açılacak," *Zaman,* October 27, 2003. http://arsiv.zaman.com.tr/2003/10/27/haberler/h9.htm.

46 "Akdağ: İş Bırakacak Doktorlar Hakkında Soruşturma Açılacak," *Zaman,* October 27, 2003. http://arsiv.zaman.com.tr/2003/10/27/haberler/h9.htm. (See appendix C.160 for the original.)

cies in general and the draft law on fixed-term contracts for health care personnel. Gencay Gürsoy was chair of the Central Council of the Turkish Medical Council at the time and stated that

> our first aim with such strikes is to share the wrongs of the health care system with the people and search for a dialogue with the government. The Ministry of Health budget should increase by 5 percent in 2004 and by 10 percent the following year. Health is among the essential duties of a social state. Patients should not be seen as clients, and the salaries of doctors should be doubled.[47]

Akdağ commented on the strike's supporters as follows:

> They want the model of socialist countries of the 1960s. This model was appropriate for those times within a statist framework, but we are now in 2003 and heading in the direction of Europe; we cannot go the opposite direction of Europe and the world. We are in 2003, but our friends are living in the 1960s.[48]

The opposition of the TTB, as mentioned earlier, is presented as holding back government efforts to apply a contemporary standard, which is expressed as European.

The strikes and demonstrations of doctors are presented as at the expense of citizens for the sake of the self-interest of doctors. Following the 14 March 2011 demonstrations, Recep Akdağ stated that

> one has to make a comparison with the previous situation, as well. The Che Guevara banner in the demonstration has nothing to do with the health care system. I can't remember the chambers of medicine coming together with marginal groups to organize such demonstrations

47 "Tabip Odası: Bu bir uyarı Eylemi; Bakan Akdağ: Demokratik Hak," *Zaman,* November 6, 2003. http://arsiv.zaman.com.tr//2003/11/06/haberler/h10.htm. (See Appendix C.161 for the original.)

48 "Akdağ: İş Bırakacak Doktorlar Hakkında Soruşturma Açılacak," *Zaman,* October 27, 2003. http://arsiv.zaman.com.tr/2003/10/27/haberler/h9.htm. (See appendix C.162 for the original.)

> against the health system in the past. I wonder, were there any demonstrations for the problems of citizens 8-10 years ago. Because they have had 'ideological ideas' since their establishment, it is because of their 'immobility' that I do not agree with their ideology.[49]

The positions of the TTB and the Medical Chambers are presented as irrelevant to the structural issues that directly impact citizens and as reflections of their –according to the Ministry of Health- outdated political identity.

As mentioned, another common theme emerging in the news articles is that the strikes left patients in a bind. Patients are portrayed as not supporting the strikes as they - it is claimed- directly suffered the consequences. For example, in an article entitled "Unfriendly Demonstration" it is stated that "patients were frustrated as they could not get any services; striking doctors faced the negative reactions of patients as only emergency and cancer patients were accepted into the hospitals. The Association of Patients and their Families (Hasta ve Hasta Yakını Haklarını Savunma Derneği or HAYSAD) stated that these strikes abused patients and that using a megaphone close to a hospital was highly inappropriate behavior by health professionals."[50]

Other articles published following the strikes also present stories of patient discontent. In an article entitled "When doctors went on strike the relatives of patients had to do the nursing,"[51] the story of a paralyzed patient who was refused an examination by a doctor and the story of a 80-year-old man who had to wait on a stretcher in the rain were given as examples of situations that patients were experiencing as a consequence of the strike.

In an article entitled "Doctors Went on Strike and Patients Rebelled" it is stated that "patients are losing their temper as doctors have been on strike four times in the last four months. Patients who were supporting the doctors have changed their minds. The patients say that 'while the doctors are asking for an

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49 "Vatandaşın Çektiği Sıkıntılar için Hangi Eylemi Yapmışlar?" *Yeni Şafak,* March 15, 2011. (See appendix C.184 for the original.)

50 "Sevimsiz Eylem," *Yeni Şafak*, March 11, 2004.

51 "Doktorlar İş Bırakınca Hasta yakınları Hemşirelik Yaptı," *Zaman,* November 6, 2003. http://arsiv.zaman.com.tr//2003/11/06/haberler/h8.htm.

increase in their salaries, we are not being treated.' "[52] As this quote exemplifies, the strikes are not only presented as having a direct, negative impact on patients but also as not being supported by patients. Recep Akdağ said, "While we are working hard so that more patients can go to the hospital, others are trying to make it so that people cannot go to the hospital."[53]

In sum, as this subsection demonstrates, *Zaman* and *Yeni Şafak* newspapers portrayed the strikes and demonstrations against the HTP as actions to prevent the improvement of the health care system that the government is trying to achieve. This shows that the self-interest of strike organizers- mostly equated with doctors- is the sole motivation for opposition to health care reform. In other words, as with other topics discussed in this chapter, the providers-receivers split was also central to the pro-government media's presentation of opposition to the HTP.

§ 5.5 "Celebrating" Reform and the Novelties of the New Health Care System

The novelties in the title of this subsection refer to changes of practice introduced by AKP governments that were claimed to increase access to and the quality of health care services.

Articles on legal changes in the health care system and their consequences will be examined under three headings. Firstly, there are groups of articles that focus on practices leading towards universalism in the health care sector. These practices eliminate differences among the diverse social security schemes; in other words, they provide services to certain members of social security schemes that were not previously available to them. The titles of the articles suggest that these new practices are an "unprecedented" novelty, most being formulated as: "from now on members of *abc* can also get the service

52 "Doktorlar zam istiyor, biz tedavi olamıyoruz." "Doktorlar İş Bıraktı Hastalar İsyan Etti," *Zaman,* March 11, 2004. http://www.zaman.com.tr/gundem_doktorlar-is-birakti-hastalar-isyan-etti_25051.html.

53 "Akdağ: Bazıları Hastanelere Gidilmemesi için Çaba Sarfediyor," *Zaman,* March 11, 2004. http://www.zaman.com.tr/gundem_akdag-bazilari-hastanelere-gidilmemesi-icin-gayret-ediyor_25053.html.

xyz for free." Not only the titles but the formulation of the articles suggest an unprecedented end to discriminatory differences among different social security schemes.

The disadvantaged groups mentioned in this category of articles are mostly people under the SSK scheme and citizens using a Green Card. Articles focus on cases where the novelties introduced provide opportunities or services that people under the SSK and Green Card schemes did not previously have. An article entitled "Good News for Green Card Holders"[54] is about a law proposal on a new practice allowing Green Card holders to get outpatient services from hospitals. Beforehand, ambulatory care services were not covered by Green Cards. This new practice affected 12 million citizens and is among the practices mentioned that eliminate the differences among diverse social security schemes.

The article entitled "People Covered by SSK and Green Card Holders can Obtain their Medicines Directly from the Pharmacies from 2005 onwards"[55] states that people with SSK and Green Card coverage can obtain medicines from pharmacies starting in 2005. Previously, people under these schemes had to obtain their medicines from specific pharmaceutical units. In the same news article, Akdağ states that "in the process of restructuring the ministry difficulties are acceptable, but our people need these changes."[56]

The article entitled "End to the Difficulties of Obtaining Eyeglasses for People with SSK Coverage"[57] is on the changing regulations for people with

54 "Yeşil Kartlıya Tedavi Müjdesi," *Yeni Şafak,* March 20, 2004.

55 "SSKli ve Yeşil Kartlilar 2005'ten itibaren ilaçlarını Eczanelerden Alabilecek," *Zaman*, December 3, 2004. http://www.zaman.com.tr/gundem_sskli-ve-yesil-kartlilar-2005ten-itibaren-ilaclarini-eczanelerden-alabilecek_118105.html.

56 "Bakanlığın da yeniden yapılanma dönemi yaşandığını, bu dönemde bazı sancılarla karşılaşılmasının doğal olduğunu söyledi. Ülkenin bu güçlükleri göğüslemek zorunda olduğunu belirten Akdağ, "İnsanımızın bu değişikliklere ihtiyacı var" dedi." "SSKli ve Yeşil Kartlilar 2005'ten itibaren ilaçlarını Eczanelerden Alabilecek," *Zaman*, December 3, 2004. http://www.zaman.com.tr/gundem_sskli-ve-yesil-kartlilar-2005ten-itibaren-ilaclarini-eczanelerden-alabilecek_118105.html.

57 "SSK'lıların Gözlük Alma Çilesine Son," *Zaman,* April 11, 2006. http://www.zaman.com.tr/gundem_ssklilarin-gozluk-alma-cilesine-son_274809.html.

SSK coverage to obtain eyeglasses. According to the article, starting on 3 September 2006, people with the SSK coverage no longer need to go to the provincial directorate of the SSK to have their prescription approved.[58] The Director General of the SSK in İzmir Province stated that "this new practice is bringing service to the citizens just like the new practices for purchasing of medicines."

In addition to these practices, some articles announced that citizens covered by SSK would be able to directly get services from the hospitals of the Ministry of Health, from university hospitals and private hospitals.[59] These articles emphasize both the convenience for patients as they would not need referrals for certain services, that the number of patients in SSK hospitals would decrease in line with this new practice, and that patients would be able to receive services from private hospitals.

In addition to services such as medicines and low-vision aid materials, certain novelties were introduced concerning services not previously paid for by the SSK or Green card schemes. Articles that refer to these changes emphasize an equality that did not exist before. An article entitled "People under the Green Card Scheme will be able to have Cesarean Sections"[60] is about the newly introduced rule that cesarean sections would be free of charge for Green Card owners. The article emphasizes that with the cancellation of one million misused Green Cards, the treasury gained 73 trillion lire that will be used for cesarean sections and births that require additional intervention. Beforehand, these operations were considered surgery and were not paid by the state. However, following a report of the Court of Accounts the Ministry of Health made a request to the Ministry of Finance that resulted in a decision that to permit

58 This previous practice was in order for the SSK system to check if they are eligible for obtaining lenses as their allowance is only for once every four years.

59 "SSK'lılar Mayısta Devlet Hastanesi'ne Gidebilecek," *Zaman,* April 6, 2003. http://arsiv.zaman.com.tr//2003/04/06/haberler/h3.htm "SSK'lılar, özel hastanelerden de yararlanacak." *Zaman,* April 10, 2004.http://www.zaman.com.tr/gundem_ssklilar-ozel-hastanelerden-de-yararlanacak_35496.html.

60 "Yeşil Kart Sahipleri Sezaryen Doğumu Ücretsiz Yaptıracak," *Zaman,* February 23, 2004. http://www.zaman.com.tr/gundem_yesil-kart-sahipleri-sezaryen-dogumu-ucretsiz-yaptiracak_18941.html.

Green Card holders to take advantage of those services without payment. Similarly, as stated in an article entitled "Also People with SSK Coverage will Make Use of In Vitro Fertilization Treatment,"[61] people with SSK coverage are able to receive in vitro fertilization without payment. These articles emphasize the abolition of differences in the access to certain services among people with various social security schemes. These articles, as mentioned earlier, emphasize the equality among citizens introduced by these practices.

Other articles underline that people under social security schemes will no longer be treated as inferior to others. The Minister of Labor and Social Security stated that they would not allow second-class treatment of people with SSK coverage.[62] In an article entitled "Second-class treatment of people under SSK coverage will be punished" it is stated that as of 1 January 2004, health units are open to all social security schemes. This decreased the number of patients in SSK hospitals by 25-30 %. In his statement, the minister added:

> As we are not able to add new buildings and facilities, what we are doing is to open unused health units to our citizens. When the general health insurance system is in use, citizens will be able to take services from any health unit regardless of whether it belongs to a public, university, or private institution. We will apply penal sanctioning to people who treat patients with SSK coverage as second class citizens.[63]

The common point emphasized in these articles is that in making steps towards a general insurance system, differences among patients are minimized,

61 "SSK'lılar da Tüp Bebek Uygulamasından Yararlanabilecek," *Zaman,* December 2, 2005. http://www.zaman.com.tr/gundem_ssklilar-da-tup-bebek-uygulamasindan-yararlanabilecek_234511.html.

62 "Başesgioğlu: SSK'lıya İkinci Sınıf Muameleye Ceza Uygulanacak," *Zaman,* March 16, 2004. http://www.zaman.com.tr/gundem_basesgioglu-ssklilara-ikinci-sinif-muameleye-ceza-uygulanacak_26966.html.

63 "Başesgioğlu: SSK'lıya İkinci Sınıf Muameleye Ceza Uygulanacak," *Zaman,* March 16, 2004. http://www.zaman.com.tr/gundem_basesgioglu-ssklilara-ikinci-sinif-muameleye-ceza-uygulanacak_26966.html. (See Appendix C.185 for the original.)

practices that underline the inferiority of certain groups are erased, and practices that maintain the discrimination inherent in the fractioned health system are punished.

There is an emphasis in the articles that with the changes of laws and regulations, the quality of health services is increasing. Changes introduced to primary health care units constitute the major part of these articles, which are devoted to novelties that increase the quality of health care services. An article entitled "The community health centers will be serving for 24 hours"[64] is about the instructions of Recep Akdağ, the Minister of Health, with respect to community health centers (sağlık ocakları). According to his instructions these centers would work in shifts and their emergency services would operate around the clock. This instruction was sent to the governors of all provinces in the country and was aimed to increase the quality of primary health care services. The reorganization of the emergency services of public hospitals is the subject of an article about a meeting held at the Ministry of Health. In the article it is stated that not only physical infrastructure but also the performance of personnel working in emergency services would be evaluated. Personnel who hinder the functioning of these services would be moved to other units.[65]

Decreasing disparities among urban and rural areas through new practices is another sub-theme that emerges in articles on innovation. Air ambulances for patients in areas where access by land is difficult is a practice mentioned in the articles. An article entitled "They made new friends as they saved lives" is about the number of patients carried to the hospital in air ambulances in Eastern Anatolia. In an article dated 9 April 2009 it is stated that 47 patients were transferred to hospitals in air ambulances over the previous five months. It is emphasized that thanks to this new practice, patients are no longer carried with sleds over snow. The comment of a patient carried to an emergency room is quoted: "I understand that I am a valuable member of this country when I

64 "Sağlık Ocakları 24 Saat Hizmet Verecek," *Zaman,* September 11, 2003. http://arsiv.zaman.com.tr/2003/09/11/haberler/h13.htm.

65 "Devlet Hastanelerinin Acil Servisleri Yeniden Düzenleniyor," *Zaman,* May 8, 2003. http://arsiv.zaman.com.tr//2003/05/08/haberler/h2.htm.

am transferred by helicopter."[66] The equalization of citizens living in diverse conditions is demonstrated as it was in aforementioned articles about the equalization of citizens with different social security schemes. Mobile health services provided in the eastern province of Ardahan is the subject of an article entitled "Mobile Health Services are initiated for the Villages."[67] Even though this article is dated January 2003 and does not concern structural change, it underscores the efforts of the new health ministry to introduce practices that decrease disparities among rural and urban areas and to provide medicine and services without payment to prevent health problems in their initial stages.

Patient rights are another issue that can be considered under the theme of innovations. As mentioned in the subsection on corruption, additional payments demanded from patients by doctors was prioritized by the Ministry of Health since the early days of the first AKP government. The project to establish a call center for patients to report such demands is the subject of an article in which Minister Akdağ is quoted underlining that the government considers the monetary relationship between patients and doctors problematic and that they wish to make citizens more conscious of their rights with such a call center.[68]

In addition to fighting corruption, another practice to protect the rights of patients is to establish patients' rights units in hospitals. In an article in *Zaman* it is stated that just in 2004, 7000 complaints were made to these units.[69] The title of the article is "The Ministry considers the complaints rightful." However, the article mentions that upon evaluation of the 7000 complaints made to the ministry in person or via the internet, 23 percent were considered legitimate and investigations into the health personnel considered responsible for the complaints were initiated. The article also focuses on practices initiated to

66 "Ülkemin değerli bir evladı olduğumu hava ambulansla taşınınca anladım." "Hasta kurtardıkça dost kazandılar," *Zaman,* April 6, 2009. http://www.zaman.com.tr/gundem_hasta-kurtardikca-dost-kazandilar_834250.html.

67 "Köylere Mobil Sağlık Hizmeti Başlatıldı," *Zaman,* January 16, 2003. http://arsiv.zaman.com.tr//2003/01/16/doguanadolu/butun.htm.

68 "Bıçak Parasına 444'lü hat Geliyor," *Zaman,* May 24, 2003. http://arsiv.zaman.com.tr//2003/05/24/haberler/h13.htm.

69 "Bakanlık Hasta Şikayetlerini Haklı Buldu," *Zaman,* November 30, 2004. http://www.zaman.com.tr/gundem_bakanlik-hasta-sikayetlerini-hakli-buldu_116761.html.

protect patients' rights, such as the organizing of training programs for hospital personnel and the Ministry of Health's establishment patients' rights units in primary health care units the following year. This, despite the title of the article which suggests that the ministry can already protect patients against health personnel and doctors.

In an article focusing on the Ministry's plan to organize inspections with undercover inspectors who would register with the hospitals as patients and report the problems they faced to the Ministry, Recep Akdağ emphasizes that the aim of these inspections is to understand the extent to which the projects of the Ministry since the early days of the AKP government have been realized, how patients are treated by health personnel, and the sufficiency of service quality and patients' rights units.[70] This article is similar to the articles cited in previous sub-themes in that it underlines the significant role of the Ministry of Health in particular and the AKP in general in terms of protecting citizens who had not been treated equally and were not served in the way they deserved.

§ 5.6 Concluding Remarks

In sum, this chapter demonstrates that the pro-government media's portrayal of the health sector complemented the broader discursive narrative of the government on health care reform. As the analysis of two major pro-government newspapers of the 2002-2011 period- *Zaman* and *Yeni Şafak*- reveals, the pro-government media's coverage positioned the AKP as an actor determined to end the victimizations caused by the pre-AKP-era health care system, presented changes introduced into the health care system by the AKP as unprecedented developments, and depicted opponents of the reform -namely doctors- as driven by self-interest. As with the AKP's own discourse, the antagonism constructed between health care providers and receivers emerges

70 "Sağlık Bakanlığı Hastaneleri Tebdil-i Kıyafetle Denetleyecek," *Zaman,* January 12, 2005. http://www.zaman.com.tr/gundem_saglik-bakanligi-hastaneleri-tebdil-i-kiyafet-le-denetleyecek_131308.html.

as a central theme in the pro-government media's discourse on health care reform.

Having discussed how proponents of health care reform, namely the AKP and the pro-government media, framed and represented reform, the dissertation's next part (comprised of chapters 6, 7, and 8) turns to an analysis of how the other side - the contesters - in the political debate around health care reform - framed and presented their arguments.

6

Who are the Contesters?

The preceding chapters discussed the pro-reform discourse on health as it promoted by the AKP government and pro-government media. This chapter and the following two chapters examine the other side of the public debate on health reform. I analyze the anti-reform discourse formulated by social actors who contested the AKP government's reforms to the health system.

This chapter introduces these actors who contested health reform in Turkey in the early 2000s: the TTB and others who joined them in voicing a public critique of the AKP's health reform policies. I argue that in line with arguments raised by the TTB since the 1980s, public criticism of the health reforms of the 2000s primarily claimed that they would pave the way for the privatization and commodification of health services, negatively affecting both health care receivers and providers in the long run. The ways in which this line of criticism emerged through specific issues are discussed in chapters 7 and 8.

As discussed in the preceding chapters, following the 3rd November 2002 parliamentary elections the new AKP government announced an Emergency Action Plan. The plan consisted of the government's short and medium term goals in the health sector and other areas such as public administration, education, privatization, taxation, and the stand-by agreement with the IMF. The aims in the health sector plan consisted of the abolition of distinctions among state hospitals, hospitals belonging to institutions, and hospitals belonging to

certain social security schemes; the provision of administrative and financial autonomy to hospitals; the establishment of general health insurance, a family physician system, and a solid referral system; the extension of preventive medicine; and incentives for the private sector to invest in the health sector.

In March 2003, Minister of Health Recep Akdağ announced the Health Transformation Program (HTP) that defined the steps to be made by the Ministry of Health and the government in the health sector in line with the objectives outlined in the Emergency Action Plan.

The anti-reform discourse on health emerged in the same period as the announcement of the Emergency Action Plan and the Health Transformation Program. Professional associations and trade unions gathered together to construct this anti-reform discourse that stressed that the HTP would lead to changes that would both deteriorate the working conditions of doctors and health personnel as well as diminish citizens' right to health. The concerns on both sides converged on the argument that the HTP would pave the way for a profit-oriented health care system wherein doctors and health personnel would be expected to generate profit for the institutions for which they work. In the long run, in such a system, contesters argued, people will not receive services as a right but will rather have to access it as a commodity in the market. In other words, the criticisms of the contesting actors underlined that the AKP's health policy reforms would lead to the commodification of health care services, and this would negatively impact both health-care receivers and providers. The criticisms raised on various specific issues in multiple mediums which I discuss in chapters 7 and 8 all centered on this primary concern about privatization and the commodification of health care services.

The anti-reform discourse became public through the demonstrations, strikes, and press releases organized by the TTB. The main contesting actor in this period was the TTB which led the unions and professional associations that objected to the changes proposed in the HTP. The other actors of the period were the Sağlık ve Sosyal Hizmet Emekçileri Sendikası (Health and Social Workers Union, or SES), Devrimci Sağlık İşçileri Sendikası (Revolutionary Health Workers Union, or Dev-Sağlık-İŞ), Türk Eczacıları Birliği (Turkish Pharmacists Association, or TEB), and Dişhekimleri Birliği (Turkish Dental Association, TDB).

Between 2002 to 2011, the opposition movement led by the TTB consisted not only of strikes and demonstrations but also legal objections to certain laws such as the law on the general health insurance system, the full time employment law and the law on transfer of SSK hospitals to the Ministry of Health. The legal objections were initiated by the main opposition party, the CHP, which filed objections to the Constitutional Court. Hence, the CHP emerged as another contesting actor in this period.

Yet, despite the legal actions undertaken by the CHP, the leading role in contesting health reform belonged to anti-government trade unions and professional associations led by the TTB. The legal battle around health reform was two-sided: While contesting actors objected to legal changes to the health system, the government also changed laws regarding the function of the TTB itself to decrease its say in the practice of the profession and to narrow its authority.

Before describing the decade of "white demonstrations," and "strikes" and the formation of the anti-reform discourse, the establishment of the TTB and how it is positioned in the Turkish political scene should be outlined to contextualize and provide an in-depth understanding of the opposition to Turkish health reform.

§ 6.1 Overview of the Actors: The Turkish Medical Association and Other Actors

6.1.1 *Turkish Medical Association*

The TTB in some respects acts differently from a classically-defined professional association, which can be described as an association that sets the rules of how a profession is exercised and clearly defines the professional borders that circumscribe its members – that is, it limits the profession to a specific group of people and guarantees them a set of privileges.

For instance, Frank Parkin states that:

> In modern capitalist society the two main exclusionary devices by which the bourgeoisie constructs and maintains itself as a class are first those surrounding the institutions of property and second academic

> and professional qualifications and credentials. Each represents a set of legal arrangements for restricting access to rewards and privileges. Property ownership is a form of closure designed to prevent general access to the means of production and its fruits; credentialism is a form of closure designed to control and monitor entry to key positions in the division of labor.[1]

Parkin portrays the impermeability of professions and professionalism from a hierarchical class perspective. In the literature of the sociology of professions, some have approached this impermeability in a horizontal way, using the term boundaries to refer to the impermeability of professions and using a metaphor of landscape: "If closure was the central concept in the hierarchy metaphor, boundaries play a similar role in the landscape model."[2]

The various approaches to professions in the literature, be they functionalist, interactionist, or power/organized autonomy approaches[3] or a class-perspective approach like Parkin's, define professions as an area where the exercisers claim a monopoly over a certain set of practices or body of knowledge.

It is possible to argue that the TTB has different characteristics than those of a professional association that aims solely to protect professional boundaries and define the ways in which the profession is to be exercised - in other words, an association that emphasizes closure through the medical profession.

The reasons for this difference stem from various historical, political, and social peculiarities of the Turkish context. Firstly, the absence of a doctors' union in Turkey is a factor that impacts the level of activism of the association in terms of organizing strikes, slowdowns, and demonstrations.

Secondly, the TTB's strong emphasis on the health rights of people is another characteristic that distinguishes it from associations that solely aim to protect professional rights or, as conceptualized by Parkin, create a closure.

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1 Frank Parkin, *Marxism and Class Theory: A Bourgeois Critique* (New York: Columbia University Press, 1983), 47-48.

2 Andreas Liljergen, "Key Metaphors in the Sociology of Professions: Occupations as Hierarchies and Landscapes," *Comparative Sociology* 11 (2012): 99.

3 Sociology of Professions literature evolved in 20th century. For further discussion see Keith Mc Donald ,*The Sociology of Professions*, (London: Sage, 1995), 5.

The priority placed on the protection of public health by the medical profession is a characteristic of the Turkish context that can be traced to the Republican era. The formation of the association's political inclinations started to be shaped in the early 1970s and will be summarized in the subsection of this chapter on the presentation of the association. The roots of this strong emphasis on the protection of public health can be traced back to the 1960s when socialization of health care services was discussed. At the end of the 14th Congress of the TTB in 1965, the central council of the TTB announced its aims:

> A TTB that has all the say in all necessary organizations in order to protect public health and provide Turkish society with health services in the best possible way, and to increase Turkish doctors' standard of living.[4]

This statement demonstrates how that the association started to define its role not just as a professional association but also as a protector of public health from the 1960s onwards.

The TTB was established in 1953 and has constitutional status as a public institution according to Law No. 6023. The membership is constituted 80 percent of doctors in Turkey. Doctors without any affiliation to a public health institution are obliged to be a member of the TTB. Even though they are not obliged to be members, half of the members of the association are doctors affiliated with a public hospital.

The early years of the organization coincided with a decade in Turkey where left-leaning politics were strong, and the inclination of the institution towards a rights-based approach both for doctors and patients is rooted back in these early decades of its institutional formation.

The establishment of the TTB can be considered in parallel with the establishment of other professional organizations in republican Turkey. As Kılıç suggests, the professional chambers established in the mid-1950s aimed to

4 "Türk Toplumunun sağlık hizmetlerinin en iyi şekilde görülmesi ve halk sağlığının en iyi şekilde korunabilmesi için gerekli bütün organizasyonlarda söz sahibi bir Türk Tabipleri Birliği'ni ve Türk Hekiminin hayat seviyesini yükseltmeyi." "TTB Tarihi: Giriş", TTB, https://www.ttb.org.tr/ttb_tarihi/giris.html.

protect the rights of their members and regulate their relationship with the state upon the presumption that members all have the same interests and conflicts.[5]

The 1961 constitution eased the establishment of trade unions, which also had consequences for the health sector. By 1971, 21 of 600 unions were in the health sector. Even though the unions established in this period[6] did not last, they paved the way for the politicization of the Medical Chambers in the 1970s according to Soyer.[7]

The election of Erdal Atabek and his team to the General Council of the TTB coincides with the establishment of the Istanbul Social Security Doctors Union (İstanbul SSK Hekimleri Sendikası). Erdal Atabek states that:

> We conducted an emotional unionism and in 1965 established the first doctor's union. And three months following its establishment, it was organized throughout Turkey… What has been accomplished by the union? There was no possibility of organizing a strike or collective bargaining. But the name union itself had a prestige within SSK because of the worker's unions of the time.[8]

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5 Cengiz Kılıç, "Demokratik Kitle Örgütlerinin Dünü Bugünü Yarını," in *Bir Muhalefet odağı olarak Tabip Odaları Bir Eylem Biçimi olarak Beyaz Eylemler*, ed. Ata Soyer (İstanbul: Sorun Yayınları, 2005), 354.

6 The names of some of those unions were listed as Türkiye Memur Hekimler Sendikası Konfedarasyonu (İstanbul 1967), Türkiye Sağlık Personelleri Sendikası (Ankara, 1965), Türkiye Sıtma Eradikasyonu Personeli Sendikası (Ankara, 1965), SSK Hekimler ve Eczacılar Sendikası (İstanbul, 1965), Türkiye Hemşireler Sendikası (Ankara, 1965), SSYB Merkez ve Taşra Teşkilatı Memur ve Hizmetlileri Sendikası (Ankara, 1965), Türkiye Tıbbi Teknologlar Sendikası (Ankara 1966), Türkiye Sağlık Tesisleri Personeli Sendikası (Ankara, 1968) Ata Soyer "Türk Tabipler Birliği- Kamu Sağlık Çalışanları Sendikaları İlişkisinin Gelişimi," *Toplum ve Hekim* July- August 2002.

7 Ata Soyer "Türk Tabipler Birliği- Kamu Sağlık Çalışanları Sendikaları İlişkisinin Gelişimi," in *Bir Muhalefet odağı olarak Tabip Odaları Bir Eylem Biçimi olarak Beyaz Eylemler*, ed. Ata Soyer (İstanbul:Sorun Yayınları,2005), 370.

8 Ata Soyer "Türk Tabipler Birliği- Kamu Sağlık Çalışanları Sendikaları İlişkisinin Gelişimi," in *Bir Muhalefet odağı olarak Tabip Odaları Bir Eylem Biçimi olarak Beyaz Eylemler*, ed. Ata Soyer (İstanbul:Sorun Yayınları,2005), 370. (See appendix C.186 for the original.)

The TTB defines its aims to protect and improve public health and to work to provide health services at affordable costs that are accessible to everyone. It also aims to have a say in medical education, to protect professional ethics, to protect the interests of medical professionals in every platform, and to protect members' rights.[9]

It has branches in 64 provincial centers where there are more than 100 registered doctors. It is a member of the Health Professions Associations Group (Sağlık Meslek Birlikleri Grubu) in Turkey and a member of a forum comprised of the WHO, World Medical Association, European Medical Education Association, and European Medical Association.

With respect to the education of doctors, the TTB offers certificate programs and prepares extensive reports on medical education in Turkey. The Association also prepares reports on health costs and participates in studies that deal with violations of human rights and torture. The income of the association comes from annual membership dues and it receives no funding from the state, which is emphasized on its official website.

Since the 1970s – that is, since the election of Atabek and his group - the groups winning the majority in the biannual elections for the General Council of the TTB have always been those with similar political leanings. The structure of the TTB is at times contested from within as well as by outside opponents, in our case the government, for going beyond its duties as a professional association and acting like a trade union.

The criticisms from within converge on the idea that the focus of the TTB should be solely on the protection of doctors' rights and that it not give opinions on current political affairs.[10] However, as summarized above, the TTB has

9 "Türk Tabipleri Birliği; Nedir? Ne Yapar?" TTB, http://www.ttb.org.tr/index.php/ttb/ttb-hakkinda http://www.ttb.org.tr/data/genel.php.

10 To understand the criticisms of the group that gets the majority of the votes, namely the *Etkin Demokratik Katılım Grubu* for the general council of the TTB, the pre-election declarations of the rival groups are useful. For instance, the pre-election statement of *Türkiye Hekim Platformu,* which can be defined as being in line with the current government, is as follows: "We believe that TTB should be free of all sorts of ideological obsessions and it should be concerned with the problems of the doctors by abiding to laws and fundemental ethical norms, the rights of the doctors can only be defended with an effective dialogue." "TTB'nin her türlü

filled the role of a doctors union in Turkey in practice since the 1970s. The activities of the TTB were stopped following the 12th September 1980 military coup. On 29th December 1980, the martial law administration allowed the TTB to resume operations regarding member registration and dealing with the wage issues of their members on the condition that it not hold any politically-oriented meetings or make any such declarations.

Before providing the chronology of the strikes that took place between 2002-2011 to oppose the Health Transformation Project, it should be noted that the TTB was also a contesting actor with respect to the health policies of governments in the 1980s and 1990s and organized demonstrations to voice their criticisms. Additionally, the journal *Toplum ve Hekim* published by the TTB was revived after the compulsory pause following the 1980 coup, and a publication entitled *Memorandum* was issued by the TTB on November 1984 focusing on the personal benefits (özlük hakları) of doctors.[11]

The first demonstration in the post military coup period took place in 1988 when a group of TTB members decided to hold a demonstration in reaction to the remark of İmren Aykut that "doctors cannot get enough of money." On 23 October 1988 the first rally was organized and the doctors brought up the

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ideolojik saplantıdan arınmış, yasalara ve temel etik normlara bağlı kalarak ve ülkenin birliği ve bölünmez bütünlüğü ilkesinden taviz vermeden hekim sorunları ile ilgilenmesi gerektiğine ve hekimlerin haklarının ancak etkin diyalogla korunup iyileştirilebileceğine inanıyoruz." "Türkiye Hekim Platformu: Özlük Haklarındaki Düzenlemeyle ilgili Çalışmalarımız Devam edecek," Medimagazin, June 29, 2009, http://www.medimagazin.com.tr/hekim/meslek-org/tr-turkiye-hekim-platformu-ozluk-haklarindaki-duzenlemeyle-ilgili-calismalarimiz-devam-edecek-2-14-20866.html. The other group that runs for the office of General Council is *Hekim Güçbirliği Grubu* which can be classified as a group that embraces a nationalist left stance that defines the main difference of their group from the *Etkin Demokratik Katılım Grubu* as the sole priority of the General Council of the Association to be protecting the intersts of the doctors. "Neden Hekim Güçbirliği?" Hekim Güçbirliği, last accessed September 10, 2016. http://www.hekimgucbirligi.org/L/TR/mid/388/Neden_Hekim_Gucbirligi.htm. (See appendix C.187 for the original.)

11 Ata Soyer, "1980-90 arası TTB-Tabip Odaları, Beyaz Eylemler, Tartışmalar," in *Bir Muhalefet odağı olarak Tabip Odaları Bir Eylem Biçimi olarak Beyaz Eylemler*, ed. Ata Soyer, (İstanbul:Sorun Yayınları,2005), 131.

insufficient share of health in the budget and the impossibility of resolving the problems of both health care receivers and providers.[12]

1988-1990 was the most active period in terms of doctors voicing their criticisms through demonstrations and should be considered in the context of the '89 spring' when workers in public enterprises unified following a deadlock in bargaining during the contract renewal of 600 thousand workers. A series of strikes then took place through the end of 1991.[13]

The "white demonstrations" that took place in May and June 1989 emphasized the quantitative and qualitative decline in public health services, the tendency toward privatization and monopolies, and the 80 percent loss of real wages that took place among health personnel in a decade.[14]

Considering this oppositional activism carried out by the TTB in the 1980s, it is clear that the arguments of three decades ago overlap with those that the TTB raised during its contestation of health reform in the 2002-2011 period. In both the 1980s and early 2000s, contesting doctors emphasized that their main priority was improvement of health services and protection of their professional rights. As they argued, government policies that prioritize privatization and profit maximization were the main obstacle to realizing their primary concern.

6.1.2 *SES and Dev-Sağlık-İş*

The SES is in the Kamu Emekçileri Sendikaları Konfederasyonu (KESK; Confederation of Public Employees Trade Unions), which is a leftist confederation for public officers in Turkey. It was established in 1996 with the unification of the Tüm Sağlık ve Sosyal Hizmet Emekçileri Sendikası (Tüm Sağlık – Sen; All Health and Social Workers' Union), Genel Sağlık ve Sosyal Hizmet Kolu Kamu Çalışanları Sendikası (Genel Sağlık –İş; General Public Health and Social

12 Ata Soyer, "Hekimlerden Sağlık Çalışma Koşullarına Tepki: 'Beyaz Yürüyüş'" in *Bir Muhalefet odağı olarak Tabip Odaları Bir Eylem Biçimi olarak Beyaz Eylemler*, ed. Ata Soyer (İstanbul:Sorun Yayınları,2005), 143.

13 Mustafa G. Doğan, "When Neoliberalism Confronts the Moral Economy of the Workers: The Final Spring of Turkish Labor Unions," *European Journal of Turkish Studies* 11, (2010):10.

14 Ata Soyer, "Beyaz Eylemler: Nereden Nereye?" in *Bir Muhalefet odağı olarak Tabip Odaları Bir Eylem Biçimi olarak Beyaz Eylemler*, ed. Ata Soyer (İstanbul:Sorun Yayınları,2005), 160.

Workers' Union), Sağlık ve Sosyal Hizmet Çalışanları Sendikası (Sağlık-Sen; Health and Social Workers' Union), and Sosyal Hizmet Çalışanları Sendikası (Sosyal Hizmet – Sen; Social Workers Union). Any employee in the public health and social work sectors can become a member, and the main agenda of SES from the time of the announcement of the HTP was the law on family physicians, the privatization of state hospitals, and support for free, accessible health services. It publishes news bulletins.

Dev-Sağlık-İş is part of the Devrimci İşçi Sendikaları Konfederasyonu (DISK Revolutionary Workers' Union Confederation), was established in 1973, and was active until the 1980 military coup. It was reopened in the mid-1990s following the reopening of DISK. Subcontracting, the problems of sub-contracted workers, health reform, and the problems of women workers are among the primary issues on its agenda.

§ 6.2 Responses of the Contesters to the HTP

6.2.1 *A Chronology of Strikes and Demonstrations from 2002-2011*

The TTB organized strikes following the announcement of the HTP under the title: *G(ö)revdeyiz* which translates to "we are on duty." There is a play on words wherein *görev* means duty and *grev* means strike. Thus, through not only the arguments it raised but also the name given to the strikes, the TTB chose to underline strikes as a duty to draw attention to the consequences of health care reforms proposed by the AKP. Every strike organized from 2003 to 2011 took place as a general response to the AKP's health policies and as a reaction to a specific legal change regarding the health system.

During the strikes and demonstrations, the TTB and other actors voiced criticisms of the government's health policies. They emphasized that policy changes made within the framework of the Health Transformation Program paved the way for a commodified health system wherein health would become less of a citizen's right and where health-care providers would become workers in a system that prioritizes profit maximization. Additionally, health care providers that participated in these strikes and demonstrations brought forward specific issues that were on the agenda at the time.

The first major strike organized by the TTB and also supported by SES was on 5th November 2003. Recep Akdağ, the Minister of Health at the time, was visited in his office a week in advance and informed about the strike by the General Council members of the TTB. The strike was announced with the title "We are on duty for equal and accessible health services, for our job security, and for a wage with which we can live humanely." The TTB listed its reasons and justifications for the strike as follows: the need to stop the "Health Transformation Program" prepared in line with directives of the WB to privatize health services; the fact that General Health insurance would bring an extra health tax for citizens, and health expenditures should be covered through the state budget rather than through premiums; the need to stop the liquidation of SSK hospitals through transfer to the Ministry of Health; the necessity of increasing the number of community clinics; the urgent need to increase the wages of doctors; and the need to change performance-based payments which led to the deterioration of patient-doctor relations and of the work climate.[15]

The 5th November 2003 strike was significant as the first of the "we are on duty" strikes and it became a symbolic event for a decade of contesting the reforms proposed by the AKP in the health sector. Participation in the strike was high. In Istanbul, the strike was organized by Istanbul Health Platform composed of the Istanbul Medical Chamber, Istanbul Chamber of Dentists, Istanbul Chamber of Pharmacists, Istanbul Chamber of Veterinaries, Dev-Sağlık-İş, and Çağdaş Eczacılar Derneği. In the rest of Turkey, it was organized together with SES.[16]

The next strike was organized on 24th December 2003. Following the 5th November 2003 strike, doctors demanded a meeting with the then prime minister Recep Tayyip Erdoğan and when they could not receive a reply to their demand they decided to continue their demonstrations until they got an answer. The demands before the 24th December 2003 "we are on duty" strike

15 "Hekimlerin 5 Kasım Bildirgesi," İstanbul Tabip Odası, November 5, 2003, http://istabip.org.tr/395-hekimlerin-5-kasm-2003-bildirgesi-.html.

16 "Sabırtaşı Çatladı: Sağlıkta Dönüşüm Programına karşı 5 Kasım'da Görevdeydik," Sendika.org, December 10, 2003, http://sendika10.org/2003/12/sabirtasi-catladi-saglikta-donusum-programina-karsi-5-kasimda-gorevdeydik/.

were summarized as: The need to dedicate sufficient funds to health from the state budget; everyone who has a Republic of Turkey ID card should receive equal and free health services, the salaries of doctors and health care workers should be increased and there should be special service compensation for doctors who work in *"hardship areas"*[17] The General Council of the TTB declared the 5 November 2003 strike was a warning to the government and the 24 December 2003 as the start of a struggle. "We are not playing a game, we just want to practice our profession" stated Eriş Bilaloğlu during a press meeting held the day after the strike.[18]

On 10 and 11 March 2004, a strike was organized as a general response to the AKP government's health policies but also as a specific response to performance-based payments introduced by the government. Before this regulation, the income accumulated in revolving funds were distributed to doctors and health personnel depending on seniority and title. However, with the regulation introduced in 2003,[19] the payments started to be distributed according to the income generated by the doctor or clinic.

On 19 November 2004, a call for a large scale demonstration was made by the Labor Platform which was established in July 1999 by 16 constituents; the Türkiye İşçi Sendikaları Konfederasyonu (TÜRK-İŞ: Confederation of Turkish Trade Unions), Hak İşçi Sendikaları Konfederasyonu (HAK-İŞ; Confederation of 'Justice Seekers' Trade Unions), Devrimci İşçi Sendikaları Konfederasyonu (DİSK; Revolutionary Workers' Unions Confederation), Kamu Emekçileri Sendikaları Konfederasyonu (KESK; Confederation of Public Employees Trade Unions), Türkiye Kamu Sendikaları Konfederasyonu (Türkiye KAMU-SEN; Confederation of Turkish Public Unions), Memur Sendikaları Konfederasyonu (MEMUR-SEN; Confederation of Public Servants' Trade

17 "Hekimler 24 Aralıkta Yine G(ö)revde," Bianet, December 22, 2003. http://bianet.org/bianet/saglik/27770-hekimler-24-aralikta-yine-g-o-revde

18 "Oyun oynamıyoruz, mesleğimizi yapmak istiyoruz." "TTB Merkez Konseyi 24 Aralık'ı değerlendirdi…"Yeni başladık!"" TTB, December 15, 2004, http://www.ttb.org.tr/TD/TD116/17.php.

19 "Performansa Dayalı Ek Ödeme Sistemi," Sağlık Bakanlığı, https://kalite.saglik.gov.tr/index.php?lang=tr&page=290.

Unions), Türkiye İşçi Emeklileri Cemiyeti (TUED; Turkish Pensioners' Association), Tüm İşçi Emeklileri Derneği (TÜMEMEKDER; Retired Workers' Association), Tüm Bağ-Kur Emeklileri Derneği (Bağ-Kur Pensioners' Association), Türk Mühendis ve Mimar Odaları Birliği (TMMOB; Turkish Union of Engineers and Architects), Türk Diş Hekimleri Birliği (TDB; Turkish Dental Association), Türk Eczacıları Birliği (TEB; Turkish Pharmacists Association), Türk Tabipleri Birliği (TTB; Turkish Medical Association), Türk Veteriner Hekimleri Birliği (Turkish Veterinary Medical Association), and Türkiye Serbest Muhasebeci Mali Müşavirler ve Yeminli Mali Müşavirler Odaları Birliği (TÜRMOB; Union of Chambers of Certified Public Accountants of Turkey). This demonstration was organized in response to the transfer of SSK hospitals to the Ministry of Health. The demonstration was held in Ankara with the title "We want a Social State and Social Justice." The deputy president of the TTB stated that: "a legal framework has been prepared to demolish public services and create uncontrolled domination by the market."[20]

On 21st April 2005, a strike was organized by the TTB and SES in general against the health policies of the AKP government and specifically as a reaction to the introduction of the Regulation on Appointment and Transfer (*Atama Nakil Yönetmeliği*) and the Law on general health insurance. The TTB argued that according to the Regulation on Appointment and Transfer, appointments would be arbitrary, based on political concerns, without taking scientific and professional compatibility into account.[21] The TTB also listed the need to stop the initiative to open 15 new medical schools among their demands.[22] DİSK, TÜRK-İŞ and HAK-İŞ also declared their support for this strike.[23]

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20 "Kamunun tasfiyesi ve vahşi ortamın yaratılması için hukuki çerçeve yaratılmaya çalışılıyor." "Yüzbinler Alanlara İniyor," *BirGün,* November 19, 2004. http://www.birgun.net/haber-detay/yuzbinler-alanlara-iniyor-22140.html.

21 "Hükumet Sağlık Hakkını Yokediyor," BIANET, April 21, 2005, http://bianet.org/bianet/saglik/59689-hukumet-saglik-hakkini-yokediyor.

22 "Doktorlar iş Bırakacak," BIANET, April 12, 2005, http://bianet.org/bianet/saglik/58868-doktorlar-is-birakacak.

23 "Sağlık Emekçilerine Sendikalardan Destek" BIANET, April 19, 2005, http://bianet.org/bianet/emek/59522-saglik-emekcilerine-sendikalardan-destek

A rally was organized by DİSK, KESK, TMMOB, and TTB on 17th December 2005. The title of the rally was "Big Ankara rally against poverty, unemployment, and injustice."[24] Another motto of the rally was "Democratic Turkey, budget for the people." The main emphasis was to argue for free education and health services.[25]

A large scale demonstration was organized by SES on 17th November 2006 with the title "Stop the destruction in health." There were a series of events organized by SES that started on 13th November 2006 in Edirne and Van, continued in Istanbul, and concluded in a large scale demonstration in Ankara on 17th November 2006. The meetings were organized to underline how the Health Transformation Program was destroying the health system according to them. They also emphasized that the transfer of SSK hospitals, the share of health in the budget, increases in outsourced labor and service procurement, and lack of investment in infrastructure had caused a deterioration of health services and pose a risk to health.[26]

During March 2007, a series of "White Demonstrations" were organized by the TTB and supported by SES and Dev-Sağlık İş. These demonstrations took place mainly in response to the Omnibus Bill *(*Torba Yasa) being passed by the government which introduced series of changes to the health care sector including the closure of community clinics and, introduction of a general practitioner/family physician model, increase of average working hours for health personnel up to 45 hours a week, and increase of the workload for radiology technicians.[27]

The "white demonstrations" were followed by a "We are on Duty" (*G(ö)revdeyiz*) strike by doctors. On 14 March 2008, a partial strike was organized focusing on the General Health Insurance Law and it was supported by

24 "Emekçiler Bütçeye ve Hükumete Hayır Dedi," BIANET, December 19, 2005, http://bianet.org/bianet/emek/71772-emekciler-butceye-ve-hukumete-hayir-dedi.

25 "17 Aralık'ta Kızılay'dayız." *BirGün,* December 9, 2005, http://www.birgun.net/haber-detay/17-aralik-ta-kizilay-dayiz-25269.html.

26 "SES Sağlıkta Yıkım Programına Karşı Yürüyor," BIANET, November 13, 2005, http://bianet.org/bianet/saglik/87672-ses-saglikta-yikim-programina-karsi-yuruyor.

27 "Beyaz Eylem Başladı," *BirGün,* March 1 2007, http://www.birgun.net/haber-detay/beyaz-eylem-basladi-31936.html.

other labor confederations. On 13 March 2011, a large-scale meeting was organized by the TTB in Ankara with the title "Many Voices One Heart". The main theme of the meeting was to demonstrate opposition to privatization in the health sector in particular and the Health Transformation Program in general. The meeting was followed by a two-day strike on 19th and 20th April 2011 that was again organized in response to privatization and deteriorating working conditions in the health sector.

The agenda of the opposing actors was based on the policy changes introduced by the government in the 2002-2011 period. In the 2002-2011 period, the Full Time Employment Law, which was on the agenda of the Ministry of Health in 2010 and introduced restrictions on the working arrangements of doctors in the public sector, occupied a significant place in the oppositional arguments of the TTB.

Thus opposition actors, mainly the TTB, focused more on resisting this legal change from 2010 onwards, and their public critique shifted to issues related to doctors' working conditions. In turn, this partial shift of focus was underscored by AKP governments and pro-government media to strengthen their representation of doctors as a privileged group concerned solely with protecting their own interests. In the end, the public debate around health reform - a major restructuring with consequences for the whole population – was boldly framed as a struggle between the government and contesting actors on the issue of the full-time employment law.

6.2.2 *Legal Struggles and Activism through Publications*

A legal struggle went hand in hand with the demonstrations and strikes of the TTB and other unions which resulted in the annulment or withdrawal of certain articles of laws proposed by the government regarding the health sector.

The legal processes concerning the "Omnibus Law" (*Torba yasa*) that passed in 2007, the General Health Insurance Law, and the Full Time Employment Law attracted the most public attention. Among these, articles concerning the employment of doctors in the private sector in the full time employment law were annulled after 4 years in 2014. Certain articles of the General Health Insurance Law were annulled by the Constitutional Court. These legal

actions pursued by the TTB and, when the application of a political party represented in parliament was needed, by the CHP. Apart from the General Health Insurance law, legal struggles over certain articles of the compulsory service and full time employment laws are ongoing.

During the same period, the government took legal action against the TTB and doctors which included changing the law concerning the status of the TTB as a professional association, and initiating investigations into doctors who participated in strikes and demonstrations.

Contesting the health transformation program was also done through publications. Some writers such as Ata Soyer, Mustafa Sütlaş, İlker Belek, and Osman Öztürk published extensively on the impact of AKP health policies both for health care receivers and health care providers. They published mainly in the newspapers *Radikal*, *Birgün*, and *Evrensel* and in online news outlets such as bianet.org and sendika.org in addition to academic publications that discuss economically, politically, and medically. Some of them, such as İlker Belek and Ata Soyer, have been writing on these issues since the early 90s, and both position the health system of Turkey within a global framework and defend a position in which ensuring public health is a priority and health care services are considered a right of the people.

§ 6.3 How Contesting Actors Differentiate and Evaluate Themselves?

In this subsection, the ways through which contesting actors define their position with respect to the HTP will be discussed through interviews conducted with them and publications of the Medical Chambers and TTB.

Interviewees working in administrative positions of the TTB and the Istanbul Medical Chamber and two people who write regularly on social security and health issues provided an overview not only of the HTP but also of how the TTB operates as something between a union and a professional association, giving the association an identity that is in between the two. To explain this, they also position their stance in the Turkish political scene since the 1970s.

Ali Çerkezoğlu, former general secretary of the Istanbul Medical Chamber, explains the possibly unique characteristic of the TTB on contestation of the HTP through the position of the TTB over the last 30 years:

> The TTB had a mission of warning both people and unions of the possible consequences of the HTP as an actor that has the capacity to foresee what would happen in the health sector and it opened the path for struggle. This might seem as a paradox, but it was the natural consequence of that period. It looks strange from a distance that a medical association reacts to the fact that the health rights of the poor are taken away from them instead of the people's organizations, democratic organizations, [and] workers unions, but when one looks at the last 30 years it makes sense. The last 30 years of the Turkish Health Association's accumulation of experience was groundbreaking for the period when the Health transformation Program was introduced, as it had always a pro-public stance, against the marketization of the health sector and always defended public health as a service.[28]

As explained in the introduction to this chapter, the TTB had worked since the 1970s to fill the void of a doctors' union. Ali Çerkezoğlu stated that:

> The tendency to be organized is very weak in our country. The TTB and Istanbul Medical Chamber are relatively more organized than the general organizational level in Turkey. The Medical Chambers and the TTB voice political demands, at times going further than their legally-defined missions and working as a union. The TTB's organizational accumulation in Turkey has a quality that goes beyond a professional association.[29]

When the position of the TTB and other contesting actors sharing the same professional and political concerns is examined, the organizational identity of the TTB is unique in the sense of working both as a professional association

28 Ali Çerkezoğlu (member of TTB General Council) tape recorded by the author, September 2012. (See appendix C.70 for the original.)

29 Ali Çerkezoğlu, (member of TTB General Council) tape recorded by the author, September 2012. (See appendix C.71 for the original.)

and a semi-union, and in that their opposition is shaped both politically and professionally.

The sociology of professions literature generally looks at how professions delineate themselves through the monopolization of expertise and knowledge as well as the boundaries they create to not only secure their places in the job market against other groups but also to use their privilege as a means to negotiate with the state. The self-portrayal and presentation of doctors while contesting Turkish health reform differs from the way the sociology of professions depicts professions as a tool to differentiate a group or discipline.

Osman Öztürk, former member of the central council of the TTB, described their role in the period when the HTP was introduced by differentiating their stance both with respect to that of their counterparts in the world and to their earlier action-taking habits:

> As I said before, our biggest action was together with SES; the strike (duty)[30] was held on 5th November 2003. As it was not a legal right it worked more as a warning action. We reacted very rapidly. We had no difficulty decoding the Health Transformation Program. Actually, it is not a new program. It also existed in the period when Yıldırım Aktuna was the Minister of Health. The privatization of hospitals, the family physician model, the general health insurance model, by us the discussion happened this way, the right-wing chambers of medicine were inclined not to oppose the program itself but instead defended only the professional rights of doctors. But we opposed this; we wanted to defend the rights of doctors and people together. We also follow what is happening in the world - the health reforms in Eastern Europe follow

30 The Turkish word for strike is grev, and the Turkish word for duty is görev, thus the strikes organized from 2003 onwards are presented by the TTB with a play of the words G(ö)rev. Through this play on words the strike is defined not just as an act done solely to protect professional rights but also as a duty to protect the right to health.

> a similar path. But we have a tradition of struggle; in this sense we can call 2003 an innovative year.[31]

Thus, even though the TTB and certain medical chambers since the 1970s were inclined not only to protect their professional rights but also to have a say on social and political matters, the period starting with the announcement of the HTP in 2003 was different in terms of the intensity of creating a discourse on the steps made by the government and planning and executing strikes and demonstrations within the framework of this discourse.

Ali Çerkezoğlu described TTB's role during the 2002-2011 period by underlining what they prioritized as follows:

> To oppose the Health Transformation Program we put forward the demand of a right to health. Instead of developing public health services, we aimed to develop the public health conscience of the people. We developed a block to slow the Health Transformation Program. From the emergency action plan onwards nothing could be realized in the foreseen calendar, and partial set-backs occurred. However, in the end it was put into action.[32]

The actions taken by the TTB in the 2002-2011 period were not only defined with respect to past years but also with respect to counterparts in the world. Osman Öztürk stated that the position of the TTB against the HTP was different, and he provided the example of how a formerly socialist country reacted on a similar issue:

> Health reform in the world is pandemic now. But there is no contestation/opposition similar to ours. They limit themselves to issues related to their profession in a narrow sense - to the interests of doctors. We went to Bulgaria in 2004 with Gencay Gürsoy;[33] they were at the time

31 Osman Öztürk, (Secretary General of Istanbul Medical Chamber and former member of TTB General Council) tape recorded by the author, September 2012. (See appendix C.72 for the original.)

32 Ali Çerkezoğlu, (member of TTB General Council) tape recorded by the author, September 2012. (See appendix C.73 for the original.)

33 Former chair of the TTB between 2006-2010

> implementing reform. And just on the eve of accession to the EU when doctors in Bulgaria supported reform there was tension. The association there stated that the 'people got used to getting services for free during socialism, now they have to get used to paying for services. We are interested in protecting the interests of doctors. Anyway, neoliberal policies are dominant in the world.' I made a presentation on our struggle here in England in 2009 at the Conference of the International Association of Health Policy. There is no similar experience to ours, especially in terms of labor. On other issues there are some broader social organizations such as the People's Health Congress and the People's Health Movement. The unions are stronger in the health sector in Europe. The uniqueness of our case has really no social scientific explanation. The biggest resistance to the WB patented reform is in Turkey. In Greece there was some resistance, too, but ours has continued nonstop since 2003.[34]

A former president of SES on the other hand stressed the importance of activism and resistance by unions and professional associations. He claimed that as they are more familiar with health-sector issues they could foresee the consequences of the HTP in advance, and it was their responsibility to share this with the people:

> We believed that all policies regarding society are and should be the concern of health sector professionals. Society does not start to make a step before seeing concrete results. We foresaw the consequences of the HTP from the beginning as we were following the health policy agenda in the world; we were more in touch with the academic community and have the experience of being organized.[35]

34 Osman Öztürk, (Secretary General of Istanbul Medical Chamber and former member of TTB General Council), tape recorded by the author, September 2012. (See appendix C.74 for the original.)

35 Köksal Aydın, (Former Chair of SES), tape recorded by the author, October 2012. (See appendix C.75 for the original.)

Statements by members of the TTB and other unions focused on how they not only focus on their own professional rights but also on the people's right to health. The perspective of Eriş Bilaloğlu, the former chair of the TTB, stresses how criticism of health reform cannot be divided into professional concerns and concern for the public. Rather, by definition, they should defend public health as part of their profession. Eriş Bilaloğlu, a former president of the central council of TTB summarized this as follows:

> When you asked citizens, they used to say that the health system changes with every government and with every Minister of Health. We used to tell people that the health system is not changing, the actors are only contributing their own colors to the system. The commercialization process of the health system does not change. We defined our duty in the following way: we are a professional association and the expectation from us is to protect the professional rights of doctors according to their interests. However, the TTB has never been such a professional association neither before nor after the 80s. We defined our duty as to protect the health rights of all people and cure them when they are ill. People define it narrowly; thus they create the dilemma of the rights of doctors and patient rights. We tried to interpret the reform from this perspective. We have a guideline in mind - a professional who protects the right to health. A profession which is fully dependent on the market cannot do this. If someone sees himself as an actor in the market, he cannot protect anyone's right to health. We regard marketization as a process that holds doctors back from practicing their profession. Doctors do not have opposing but instead overlapping interests with the public. Our attitude is to stand by doctors and the people's right to health at the same time. What we want to preserve in this system are not the parts that do not function, such as the bad practices of private consulting rooms [and] a malfunctioning public health system. We were already critical of the health system in the 1975-1980 period. We defined our front of opposition - opposition

> not in the narrow sense of rejecting an idea, but as a position that defines how the health system should be.[36]

Not all actors who took part in opposing the HTP in the 2002-2011 period found the results satisfying, but most agreed that this period created awareness. Though the self-criticisms of the contesting actors is the subject of another subsection of this chapter, the statement of Ersoy Adıgüzel, a former president of the Aksaray Branch of SES, is a summary self-evaluation that covers both what was unique and what was lacking in that period:

> Our evaluation of the Health Transformation Program was sound at the time it was announced. However, we could not execute a coherent resistance program as there were difficulties in establishing the "people" pillar of the struggle. We could not put into action demonstrations that would work to withdraw or annul the government's proposed laws on health policy. Health workers had an opposition agenda, but it turned into a process of protesting. I mean before a law proposal is discussed in parliament, if it were explained to the public thoroughly with a coherent propaganda, we would be at a different stage today. The action program could not be fully executed. We are contestants, but our demonstrations could not go beyond protesting. I do not include what has been achieved in Çapa and Cerrahpaşa, but in general the demonstrations could not go beyond protesting. SES has always been a dynamic union which had a say in the political agenda of the country; it did not only voice the social and personal benefits of union members.[37]

The main concern that will be discussed in detail in the last subsection of this chapter on the nature of the contestation, is that the contestation was mainly limited to service providers and was not voiced by service receivers. Even though service providers stressed in their discourses that their concern was

36 Eriş Bilaloğlu, (Former Chair of the General Council of TTB) tape recorded by the author, October 2012. (See appendix C.76 for the original.)

37 Ersoy Adıgüzel, (Chair of Aksaray Branch of SES), tape recorded by the author, October 2012. (See appendix C.77 for the original.)

not only their own interests, the absence of a strong voice among patients strengthened the discourse of the government that positioned service providers as a group that cares only for their own interests and oppose health reform for their own material benefits at the expense of better service. Adıgüzel also stresses that despite these shortcomings the most important contribution of this contesting movement was that it created awareness.

Members of the executive board of Dev-Sağlık-İş, on the other hand, defined their role as trying to bring the two victims sides of the HTP - patients and outsourced workers - together. He stressed that they focus solely on outsourced workers as they think that they experienced the greatest problems.

> There are two victims of the Health Transformation Program. The first group is the patients who will gradually be deprived of quality services. Everybody had the same thing in mind in the past, when some blood test or x-ray was requested at a private hospital, people used to wonder if it was really necessary. Now people ask the same question when they go to public hospitals, as well. For example, in Beykoz Public Hospital the chief-physician issued a circular which ordered that all patient registrations had to be done through the emergency unit. All of them should be hospitalized. This new system leaves people alone, and people try to create solutions. The biggest problems are experienced by outsourced workers. Stipends decreased; even the stipends of people with a minimal wage decreased. We decided as a union to bring the two sides together. What we have done in the last 10 years? Awareness. It never turned into a social movement. It did not become a movement that had the power to stop what is going on in the health system. We were on one side defending public health, on the other side there was a very powerful government that defended marketization. We could not stop the Health Transformation Program, but we created an awareness. In the demonstrations patients supported us. In the first years we

did not have that kind of support, but in time we created an awareness.[38]

The contesting actors mainly focus on the fact that despite the lack of a social reaction to the HTP, their actions conveyed their discourses to the people. And even if they could not change the course of the HTP, they delayed the passing of laws and most importantly, according to them, created awareness. The actors underlined most that they not only oppose the reforms for their own interests but also for the health rights of the people.

They emphasized that their main difference from foreign counterparts was the importance they placed on the health rights of the people and the marketization of the health sector, which according to them harms both service providers and receivers in the long run. Through this discourse they claimed the opposite of the AKP's portrayal of doctors as opposing the HTP in order to protect their privileges, thereby victimizing the people.

§ 6.4 How Contesting Actors Evaluate the Health Transformation Program

The discussions and discourses on the health sector were intense during the 2002-2011 period, as discussed in the previous section dedicated to the AKP's use of health as a field of political discourse. This provided an area over which the AKP could make broader, concrete claims of justice and equality. Those opposing what the AKP proposed and implemented in the health sector (on health policies and on issues regarding both providers and receivers) intensely discussed all these issues in this period. According to them, this period had no equivalent in the Turkish health scene and created irreversible changes. Thus, their reaction was inevitable.

Initially, they emphasize that despite shortcomings, the preceding system still possessed fundamental qualities which according to them were indispensible. They underline that there was a struggle even in the pre-AKP period, but that this struggle took place in a field where there was a notion of public health

38 Tufan Sertlek, (Former Secretary General of Dev Sağlık-İş), tape recorded by the author, July 2012. (See appendix C.78 for the original.)

services. Ali Çerkezoğlu, former Secretary General of the TTB, explains the issue:

> In the pre 2003 period there was a struggle against the destruction of community clinics, against the practice of revolving funds, for an increase in the share of health in the state budget, [and] an increase in the incomes of doctors and health care personnel. But during those years there was always a public system. Our struggle was to improve its qualities and to increase the personal benefits of health sector employees. In this new period no new public hospitals have been opened but instead health services are shifted to private hospitals which are consumption-oriented and, the SGK is transforming into an institution that does not provide but rather purchases services.[39]

The main concern of the opposition is the shift of services to private providers and the transformation of the social security institution into a service purchaser.

The difference of the HTP is also explained by the different qualities the AKP possessed from those of its predecessors. One of the main differences is explicitly marketizing health services and attempting and realizing fundamental changes. Tufan Sertlek, a member of the administrative board of Dev-Sağlık-İş, summarized the peculiarity in this respect in the following way:

> The AKP declared what even Özal could not openly say: "The state should not provide health services." It did so by relying on the high percentage of votes it got. It has three pillars this thing, and it invaded the health sector. But some things before the AKP were still there, some of them are still there. The preventive health care services etc. Law number 2024 was still there; it is a very good law that defined preventive health care services. The hospitals were still the property of the state, even though health care depended on premium, services were provided free of charge. There was a public social security umbrella under the SSK, Emekli Sandığı and Bağkur. These have been integrated

39 Ali Çerkezoğlu, (member of TTB General Council) tape recorded by the author, September 2012. (See appendix C.79 for the original.)

> into the liberal system by the AKP. That was what the AKP did basically. It integrated these three pillars into the liberal system. The backbone of the health system were those, and they managed to collapse it. Problems will proceed through these three areas. The community clinics changed into family physician clinics that are in reality private practices; the state just provides support for electricity, water, and rent. After some point they have to take care of themselves without support.[40]

Thus, what can be inferred from opposition discourses is that the consequences of the reforms in the long term would deprive people of their health rights because access to preventive care services would be bound to premium payments, and the status of the state changes from that of a provider of services to a purchaser of services. Ali Çerkezoğlu summarizes what sets the HTP apart and how this will be experienced in the long term as follows:

> It is fundamentally different this one. The changes proposed or made in the last 30 years formed a basis but none of them made a structural change; they were momentary changes mostly regarding regulations. On the other hand, the HTP is structural and completely a project of the WB. The one we are faced with today has potential risks for the future. The HTP basically turns the patient into a customer. It makes the labor of the doctor cheap and makes them work flexibly.[41]

The way Turkish Health Reform was presented by the AKP and the context which preceded it are also among the advantageous factors that made it possible to realize the changes it sought. The discourse of the AKP underlined the bureaucratic procedures stemming from a fractured social security system that lengthened the time needed to access services and that patients had a limited number of places from which to receive services depending on the social security scheme they are in. This was powerful for portraying the new system as easing the lives of people and creating an unprecedented way of serving

40 Tufan Sertlek, (Former Secretary General of Dev Sağlık-İş), tape recorded by the author, July 2012. (See appendix C.80 for the original.)

41 Ali Çerkezoğlu, (member of TTB General Council) tape recorded by the author , September 2012. (See appendix C.81 for the original.)

people. This portrayal, according to Sertlek, masks the mid - and -long term consequences of the HTP:

> The advantage of the AKP was that the system preceding them had a lot of problems. A lot of bureaucratic procedures were abolished, for example. Before, people with SSK coverage could only go to certain hospitals. All the complications were eliminated, the university hospitals are about to be included into this system. Now there is no need for a referral. In the beginning the copayments made to private hospitals were lower, and private hospitals were the opposite of what people complained of most in state hospitals, such as long queues and lack of interest in patients. But now the complementary payments have increased and people are again inclined to go to public hospitals.[42]

In addition to presenting the system as better through comparison, the advantages presented in the initial phases of the HTP according to the contesters made it unique as it was perceived to be offer possibilities available not present until then. All of these, according to Çerkezoğlu, are steps towards the privatization of the health care system, and few could grasp the long term consequences:

> It provided candied apples in the beginning: access to private hospitals, easy access to pharmaceuticals. But the marketization of health services is an initiative of privatization. It is like Government Business Enterprises, first opened to public then transformed into an investment tool for international capital. The consequences can be clearly observed. Marketization and privatization make health not a right but a commodity. It becomes a service provided to those who have money to pay their premiums or meet out of pocket payments. In order for this new system to be accepted, the strategy was throwing out a herring to catch a whale. The increase in performance-based payments to doctors, the increased wages of outsourced health workers, and the increased short-term pharmaceutical expenditures of the people are all

42 Tufan Sertlek, (Former Secretary General of Dev Sağlık-İş), tape recorded by the author, July 2012. (See appendix C.82 for the original.)

> examples of practices to make the structural changes look attractive in the short term. People think that they have access to better health services, and only people with an education and a clear political stance can understand what is going on.[43]

The role and usage of media by the Ministry of Health and the government in this respect is also mentioned while explaining the determined flow of changes through the HTP. As mentioned before in this section, the contesting actors stress that the initial changes introduced in the HTP were executed with the additional benefits presented in the short-term, which mask the long-term consequences. A statement by Sütlaş summarizes this issue:

> From the beginning I keep saying the same thing: this is a process where the media was very effective. While presenting this reform, the Ministry of Health set forth some things that were not happening in practice. The Ministry brings things into practice through giving financial support and gets positive results. In reality, when one looks at the family physician model, even though it is communicated this way, people have to make out-of-pocket payments, but in the first instance it is subsidized. But when the resources are spent, they will not be able to provide subsidies. When looked at, the texts that present it offer more than explanation. There is propaganda, but in reality they do something 180 degrees opposite.[44]

The most dramatic changes, according to the contesting actors, differ according to their stance or the union or association they work with. But they all converge on the privatization of health care services and people being deprived of their right to health. In this respect, the transfer of hospitals holds an important place in opposition discourses as it is a major step in the privatization of health care services.

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43 Ali Çerkezoğlu, (member of TTB General Council) tape recorded by the author, September 2012. (See appendix C.83 for the original.)

44 Mustafa Sütlaş, (Journalist, former member of the executive board of Istanbul Medical Chamber), tape recorded by the author, July 2012. (See appendix C.84 for the original.)

> The most important first step was the transfer of SSK hospitals to the Ministry of Health on 19 February 2005. It is a structural change and at the same time irreversible. It is more important than the announcement of the Health Transformation Program.[45]

In line with this, public hospital unions and performance-based payments to doctors are also believed to have fundamentally and irreversibly transformed the health scene on a profit-oriented path:

> Hospitals are transformed into enterprises. Performance-based additional payments are introduced. Since early 2004 receiving payments per patient is introduced; this is a big change, as well. Doctors earned the highest incomes in republican history and they thought it was going to last forever. The most important change introduced by the government is to transform hospitals into enterprises, like corporations. They included public hospital unions in the Omnibus Bill. It is being slowly implemented. Hospitals will have an executive board of 7 people who have all the authority over the opening and closure of hospitals and clinics.[46]

The main concern of the public hospital unions is the possibility of their transfer to the private sector and then being used for non-health sector fields in the future. On this issue, Sütlaş also underlines how, like in the other matters concerning the health sector, the presentation of the change and its execution differ:

> It has no equivalent - the composition of the board of trustees being people from the business world. When a health institution is privatized its main basis should be being engaged in an activity related to health.

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45 "Bence en önemli ilk adım ssk hastanelerinindevri 19 şubat 2005, hem yapısal anlamda hem irreversible. O tarih daha önemli."Osman Öztürk, (Secretary General of Istanbul Medical Chamber and former member of TTB General Council) tape recorded by the author, September 2012.

46 Tufan Sertlek, (Former Secretary General of Dev Sağlık-İş), tape recorded by the author, July 2012. (See appendix C.85 for the original.)

> In the drafts prepared in Turkey, what they try to do is to allow these institutions to be able to change their main activity and do something completely different. With this they aim to create something that is attractive for the market. Here the main issue is that the things they do, and that they claim to do, do not overlap. When they speak on a TV show, they say the exact opposite of what they are actually doing, and through this they maintain their prestige and gain supporters.[47]

Changes to the working conditions and personal benefits of doctors are mentioned frequently by the TTB and unions. The family physician model is criticized by the contesters as it was regarded to be both a threat to preventive health care services and also as it paves the way for outsourced work. The changing, increasing workload of doctors compared to when the model first launched is underlined:

"They make home visits on certain days of the week, and now obligatory night shifts have been introduced. They are expected to both see patients - provide primary care health services - and do the chores."[48]

Apart from criticizing individual changes, they underline that the HTP is changing the profession's general status in society, the relationship doctors form with their patients, and their profession:

> The biggest blast will be to the doctors, even more than to outsourced workers. The working conditions of outsourced workers are not directly linked to health reform. This reform process is turning doctors into workers – before, they were earning more. The transformation of doctors into workers has been done by making them disreputable and by oppressing them, especially during the process of passing the full time employment law. Actually they intervened in issues about which

47 Mustafa Sütlaş, (Journalist, former member of the executive board of Istanbul Medical Chamber), tape recorded by the author, July 2012. (See appendix C.86 for the original.)

48 "Haftanın belli günleri ev ziyaretlerine gidiyorlar. Nöbet zorunluluğu da geldi şimdi. He hasta bakacak ve devletin birinci basamak hizmetini yerine getirecek hem de angaryaları yapacak hastaneler de işletme haline getirilmeye çalışılıyor." Tufan Sertlek, (Former Secretary General of Dev Sağlık-İş), tape recorded by the author, July 2012.

> citizens complained most. They transformed doctors into workers. Doctors are a group of professionals who are addressed as Doctor, Professor, now they are beaten by patients' relatives; they are devalued. They did all this in order to transform them into workers.[49]

§ 6.5 How Contesting Actors Justify Strikes and Demonstrations

The biggest criticism of the contesting actors came right before and immediately after the strikes they organized. As discussed in detail in the 2nd part regarding AKP discourses on the HTP, the pro-reform discourse accused the TTB of protecting doctors' own rights. Especially strikes received the government's reaction stressing how the AKP was trying to improve health services while doctors were depriving the people of those services for the sake of their own benefit.

As mentioned earlier in this chapter, the strength of the anti-elitist discourse of the AKP and its positioning of itself as an actor saving the people from victimizations caused by elites of the "Old Turkey" strongly influenced doctors' protests. In this respect, at the risk of oversimplifying, it can be concluded that when doctors voiced protest regarding their profession, they almost always went hand in hand with a legitimizing discourse that underlined the importance they placed on public health. The literature on the sociology of professions cannot be completely rejected when trying to understand the standpoint of doctors as elites. Between the lines, they emphasize their ability to foresee the negative impacts of health reform while the majority of people are convinced of the reforms by their short-term benefits.

The main line of argument the TTB and other actors that took action together with them is that they object to the HTP and took actions such as strikes and demonstrations not only for their own interests but also to protect the health rights of the people. The two concerns are inseparable for them, and especially the TTB often stress that their main action point is the health rights of the people and to voice the concerns of as many different groups as possible.

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49 Tufan Sertlek, (Former Secretary General of Dev Sağlık-İş), tape recorded by the author, July 2012. (See appendix C.87 for the original.)

Ali Çerkezoğlu, former Secretary General of the TTB, summarized their objections to the HTP, their actions, and how they organized:

> The TTB and Istanbul Medical Chamber foregrounded the impact of the Turkish Health Reform not only on doctors but also on the right to health. We emphasized that the General Health Insurance law, health financing, the family physician model, and the change in public hospital structure would lead to the abolition of peoples' health rights as they are transformed into customers. We tried to make this struggle together with the people in order to maintain their right to health. We created an organizational model that included workers and state officers unions, professional chambers, NGOs, political parties and even village associations through a platform called "Health for all Secure Future for all." In its first 3-4 years, this platform played an important role with respect to rights to health and social security issues: the decrease of the number of days needed to retire from 9000 to 7200 [and] the postponement of certain articles of the General Health Insurance Law from 2006 to 2012. We had achievements, but in the end the Health Transformation Program continues.[50]

An argument that comes up frequently in the contesters' statements is how they do not distinguish between the HTP's consequences for patients from the ones for service providers. Former chair of the TTB Eriş Bilaloğlu underlined that it would be inconsistent with the ethos of the profession to act otherwise, as the language of the HTP is capitalist and turns patients into customers. If they accept this approach, they cannot continue to perform their profession as they should. He argues that the debate over the HTP has two sides:

> What we call a struggle for rights is a struggle between labor and capital. When we look at the moments decisions are made, the decisions made by the ministry are in favor of some. For example, they say 'I will bring the professor to you'. The TTB is bad for your health. This will be understood in the long run. For the moment people have access.

50 Ali Çerkezoğlu, (member of TTB General Council), tape recorded by the author, September 2012. (See appendix C.88 for the original.)

> There are two discourses at the moment: one on the side of labor, the other on the side of capital. We are on the side of labor but I am not sure if we are able to defend it. The chair of SGK got an award from the WB. We as the TTB might choose the wrong sentences at times, but we are always on the side of labor. We try to protect the health rights of the people. Otherwise we would be treating the people as customers and defining ourselves only as service providers. Otherwise we would not be doctors in the minds of people - the person they want to trust in every situation -, and it would be against the Hippocratic Oath. We are laborers and to position ourselves otherwise would be inconsistent with our profession.[51]

This statement of Bilaloğlu demonstrates how the organization of the TTB - with the stress it gives to labor - lies somewhere between a union and a professional association. As mentioned earlier, this peculiarity of the organization can be traced to the late 1960s and early 1970s when the administrative board of the TTB changed and its ethos today started to be shaped.

The discourse of the government claimed strongly that the HTP was on the side of health service receivers, as discussed in the previous part, and included arguments that underlined how the contesters were at odds with patients and how the government and Ministry of Health are protecting citizens against this privileged group of professionals. In this respect, the actors that opposed the HTP underlined that their biggest achievement overall in the 2002-2011 period was to create awareness among the people by explaining what the HTP meant from where they stand. Ersoy Adıgüzel, former executive board member of the SES Aksaray branch, provided an example:

> We set up information tents in Cerrahpaşa and Çapa right before the 19-20 December 2011 strikes. In these tents we distributed open letters we wrote for patients. These letters were on Statutory Decree No. 663, what the decree actually meant, and the Health Transformation Pro-

51 Eriş Bilaloğlu, (Former Chair of the General Council of TTB), tape recorded by the author, October 2012. (See appendix C.89 for the original.)

> gram. We collected signatures from them. As we health sector employees live in this situation, we can sense it more easily, and we communicated it very clearly to patients. We had a two-day strike on 19 and 20 December. In Cerrahpaşa and Çapa over 5000 patients and health employees held demonstrations. It was a demonstration that spread across the whole country. The demonstrations here triggered the country-wide strike.[52]

While on one hand, a consistent, powerful government discourse went hand in hand with the policy changes, on the other, the meetings and demonstrations organized by the TTB were also attended not only by doctors and health employees but also by members of the general public . Özsever cited his own observation of a TTB meeting where he witnessed the participation of people other than health sector employees and doctors to show that the protests of the TTB were not altogether ignored by the public:

> In 2008, the TTB had a meeting in Kadıköy. I observed that there were many different types of people - people that I did not expect to see. Of course union members are also people, but I am familiar with them more or less. For example, I asked a lady why she was there. She told me she had leukemia and she had bought some medicine, and then she realized some part of it was deducted from her pension, and not only from her pension but from her husband's pension. So she said that is why she was there.[53]

The loss of job security for doctors and health sector employees was underlined as a major reason for their opposition to the HTP, and Çerkezoğlu claims that practices introduced by the HTP led to precarity in the health sector:

> 2003 brought about a structural change; thus, our struggle focused on the demand of job security for doctors being dragged into a precarious

52 Ersoy Adıgüzel, (Chair of Aksaray Branch of SES), tape recorded by the author, October 2012. (See appendix C.90 for the original.)

53 Atilla Özsever, (Journalist specialized in Social Policy), tape recorded by the author, July 2012. (See appendix C.91 for the original.)

> work environment, the unjust treatment faced by doctors in community clinics and onsite doctors, forcing doctors to work as family physicians, performance-based payments, etc.[54]

Changing working conditions and precarity in the sector caused by health policy reforms that impacted all health sector employees (doctors and non-doctors) changed how doctors viewed their workplace. That was how it became possible for them to organize and act together with non-doctor health sector employees. This argument is summarized by Ersoy Adıgüzel who pointed out how transformations in health transformed the way doctors perceived their profession and the ways they related to their workplace:

> We made the aforementioned demonstrations together with the doctors. We are a union that can cooperate with the TTB. We held common demonstrations. But there is a problem at the root. Before, doctors and academics consider themselves as owners of the hospitals, but with the introduction of the full-time employment law they realized that they were becoming workers. They understood that even though they have a different status, they themselves are also people that make their living by working. In the demonstrations we organized, outsourced workers and doctors walked side by side. They understood that they had common interests and that the laws impacted everyone. As for Türk Kamu Sen and Memur Sen,[55] the members acted with us in the demonstrations against the HTP, but a unification higher up, at the administrative level, is very difficult. By higher up I mean that the defining arguments differ there, while at the base the laborers can unite.[56]

One of the main conclusions reached by the actors is that there was an unprecedented unity and strength –to some extent- in the health sector following

54 Ali Çerkezoğlu, (member of TTB General Council), tape recorded by the author, September 2012. (See appendix C.92 for the original.)

55 Pro-government unions.

56 Ersoy Adıgüzel, (Chair of Aksaray Branch of SES), tape recorded by the author, October 2012. (See appendix C.93 for the original.)

the HTP. What made their objections unique was the theme around which they came together, argues Eriş Bilaloğlu, the former chair of the TTB. They defined the concerns of health rights and job security as inseparable and as issues that impact one another:

> In some reactive moments, we experienced 10 years where very strong reactions took place compared to the past. We designed the line where doctors are included as a line based on the health rights of the people but also a line that protects workers' and doctors' rights. The government is very strong and anti-democratic - and obstructs the right to organize. But despite all this there is unity and success. What are our concrete achievements? There are none. But pensions, retirement grants, [and] the length of work time are still issues. There are 600-700 000 employees in the health sector and we can easily say that there is precarity. There is a higher organizational capacity compared to the past. Doctors are not used to coming together with other health employees; there are a lot of reasons for that. But despite those reasons, with the strong willpower of the TTB, we organized this process. We tried to organize groups that have various stances on the right and left, but some of them did not accept our invitation. The meeting of 13 March is a moment when all this crystallized as it included the whole health sector. It took in a wide spectrum of people, most of them health employees, at least half of them doctors. We managed to stand together with health employees that are not doctors.[57]

When actors that objected to the HTP evaluate the period of demonstrations and strikes, they are also self-critical and point out the weaknesses: what was missing in that period and what could have made their struggle more effective.

One line of criticism focused on how some professional associations focused on their own interests, which prevented them seeing the broader, long-term impacts of the HTP. Çerkezoğlu was especially critical of the dentists'

57 Eriş Bilaloğlu, (Former Chair of the General Council of TTB) tape recorded by the author, October 2012. (See appendix C.94 for the original.)

and pharmacists' associations, but exonerated the Istanbul Chamber of Pharmacists:

> While the medical chambers focused on stopping this program, developing an opposition to all of it through struggle, some professional chambers such as the pharmacists and the dentists, focused on the small interests of their own members or on day-to-day advantages - disregarding the broadness of the issue and the fundamental consequences of it. The Istanbul Pharmaceutical Chamber, despite its central association, had a more determined stance that took into account the broad consequences of the issue.[58]

The difficulty for some unions to adapt to and embrace new organizational structures and new modes of opposition was another point that came up:

> As for other unions such as SES that is part of KESK, they also could not manage to transform the dynamism they had in the 90s for the struggle against the Health Transformation Program. They tried to fight against the Health Transformation Program in the same manner they adopted as a state officers' union in collective contract processes in the 90s. They continued to struggle with the tools of the past in the face of a completely different program. There was a struggle, but their organizational form and outlook were not adapted to contemporary needs.[59]

A more general criticism that came up during the interviews was the perception that the health reform issue was the responsibility of the TTB and health sector unions - in other words, that this issue was not embraced as a primary concern of other unions and associations that concur with the TTB and other health-sector unions on their broader stance with respect to the AKP government. According to the interviewees, this confined the Turkish health reform

58 Ali Çerkezoğlu, (member of TTB General Council) tape recorded by the author , September 2012. (See appendix C.95 for the original.)

59 Ali Çerkezoğlu, (member of TTB General Council) tape recorded by the author, September 2012. (See appendix C.96 for the original.)

issue to the vocal capacity of the TTB and platforms organized under its leadership. Thus, the spread of the arguments that lie beneath the contestation remained limited.

§ 6.6 Concluding Remarks

To conclude, it is difficult to speak about an opposition movement and discourse equal to the government's consistent presentation of the HTP. This was a consequence of the fragmentation of contesting actors in the field. It also had to do with the fact that the oppositional discourse was formulated at a time when the short-term benefits introduced by the HTP were still in effect and long-term consequences had not yet crystallized. Thus, the government's pro-reform discourse had "concrete," "visible" consequences when compared to the discourses of the contesting actors. In other words, the reactions of the TTB and other actors remained defensive.

Despite the consistent discourse of the TTB which emphasized that the HTP would have long-term consequences in terms of the loss of the health rights of the people, the claims of the government and Ministry of Health that the HTP was making the health system more just and accessible to all were more 'tangible' given steps such as policy changes that led to access to hospitals that were not previously accessible.

Additionally, the presentation of the policy changes were in line with the broader AKP discourse of creating a "New Turkey" in which injustices stemming from elite privileges are eliminated. The introduction of compulsory service and the full time employment law, for instance, were presented in a way that underlined how the elite were made to serve the people and how equality has been brought through the elimination of "Old Turkey" privileges. The health sector was an area where the construction of justice and equality between the elites and the people were boldly solidified, and that is why its frequent appearance in AKP election campaigns is no coincidence.

Despite being in such a field where the agenda creation depended on policy changes and the opposition movement could not stop the implementation of the HTP, the conclusion of the interviewees and actors that wrote on this field were that they successfully created an awareness in people and that they

could continue their demonstrations and publications consistently despite their limitations.

7

Contesting the Privatization and Commodification of Health Services

The main contestation raised by health care providers focused on the privatization and commodification of health care services. In other words the actors, led by the TTB, argued that the HTP would pave the way for the privatization and commodification of health care services in the long run, negatively affecting both health-care providers and receivers. This chapter will highlight this argument by tracing the discourses of the TTB and other contesting actors on specific issues such as the transfer of SSK hospitals to the Ministry of Health, public hospital unions, the changes to pharmaceutical coverage for various social security schemes, and the increases in copayments and budgetary changes introduced into the health sector by AKP governments. The discussion builds on a scan and an analysis of news articles from chosen media – the dailies *Radikal, Cumhuriyet,* and *BirGün* and the BiaNet online news outlet - between November 2002 and July 2011.

As described in Chapter 6, the HTP was objected to and publicly criticized mainly by health-care providers. The representatives of health care providers were professional associations and unions and were led by the TTB. These objections and criticisms took the form of strikes, demonstrations, public announcements, though the most visible form of this opposition was legal actions taken by the TTB through the main opposition party, the CHP, which resulted in the annulment of certain articles in laws on health policy by the

Constitutional Court. Some of these laws had been vetoed by President Ahmet Necdet Sezer, such as certain articles of the law concerning general health insurance and changes to the law that permitted the recruitment of non-Turkish doctors. However, even though these vetoes were in line with the arguments of the TTB, they were not the consequence of a publicly-made cooperation between the TTB and the president.

Within the objections and criticisms of the HTP raised by the TTB and other unions, the topic of the working conditions of medical personnel and the concerns of medical professionals came up more frequently than the consequences of the HTP for health-care receivers. There was also a shift in the discourses of the TTB towards their own concerns as doctors after the full time employment law and new regulations of private practices were put on the agenda of the health reform in 2010.

It is possible to claim that together with the consistent, coherent anti-elite discourse of the AKP, the TTB's foregrounding of the concerns of the medical profession after the full time employment law created a barrier to communicating the arguments of the TTB to health care receivers.

One of the main themes under which the discourses of the TTB converge is the privatization and commodification of health care services. This theme of the discourses of the TTB will be analyzed with respect to four specific issues related to health care reform in Turkey. The transfer of SSK hospitals to the Ministry of Health is an issue that is discussed frequently by the TTB and is presented as a step towards the privatization of health care services. While bringing up privatization and commodification issues in health care services, the TTB focuses on equal health services provided to all citizens with no out-of-pocket payments and no concern for profit making. The government discourse on the transfer of SSK hospitals to the Ministry of Health focused on the equality this would bring to citizens under SSK coverage. The response of the TTB was that this transfer paved the way for the privatization of hospitals which until then had been financed through premiums paid by workers.

The second issue that came up in the discourses of the TTB is the "Kamu Hastane Birlikleri" (Public Hospitals Unions) Law which established autonomous financial and administrative structures for public hospitals in every province. According to this law, public hospitals in every province would be

gathered under a union, their budget and administration would not be centralized, and their administrative board would not consist only of doctors. The main reason for the objection of the TTB on this issue was that this model of administration would commercialize health services by transforming hospitals into profit-oriented entities.

The third issue was the share of health in the state budget, particularly how the distribution of the budget changed with the HTP. Another budgetary issue frequently put forward by the TTB concerned the medicines taken from social security scheme coverage, especially following unification of health security schemes under the general health insurance.

§ 7.1 Transfer of SSK Hospitals

The transfer of public hospitals to the Ministry of Health became an issue of debate immediately after the introduction of the draft law by the Ministry of Health.[1] The Ministry of Health in particular and the government in general presented this as a step towards bringing an end to the fractured social security system and making the Ministry of Health the sole coordinator of health care provision centers. At the time the draft law was sent by the government to the ministries for their comment, 148 hospitals, 212 dispensaries, 202 health stations, 3 dental health centers, and 2 hemodialysis centers were to be transferred to the Ministry of Health.[2] The law's preamble was Article 56 of the Constitution: "The State exclusively plans and regulates the services of health

1 The draft of the law was sent to the ministries on 28 Oct 2004. Law number 5283 "Bazı Kamu Kurum ve Kuruluşlarına ait Sağlık Birimlerinin Sağlık Bakanlığı'na Devredilmesine dair Kanun" passed on 6 January 2005 published in Resmi Gazete on 19 January 2005. http://www.mevzuat.gov.tr/MevzuatMetin/1.5.5283.pdf.

2 "SSK'ların Devri için Yasa Hazırlığı." *Radikal,* September 28, 2004. http://www.radikal.com.tr/turkiye/ssklarin-devri-icin-yasa-hazirligi-723837/.

care organizations in order to ensure the maintenance of the mental and physical health of everyone by increasing the efficiency of manpower and savings on material resources."[3]

Additionally, the preamble stated that it was prepared in line with the aim to provide equal, quality, efficient, and accessible service to all citizens regardless of their social status or the social security scheme to which they belong.[4] Professional organizations, led by the TTB, opposed this move, emphasizing that it was a step towards the privatization of public health units.

The Labor Platform, which was established in July 1999 by 16 constituents, namely TÜRK-İŞ, HAK-İŞ ,DİSK, KESK ,Türkiye KAMU-SEN, MEMUR-SEN, Türkiye İşçi Emeklileri Cemiyeti, Tüm İşçi Emeklileri Derneği, Tüm Bağ-Kur Emeklileri Derneği, TMMOB, Türk Diş Hekimleri Birliği, Türk Eczacılar Birliği, Türk Tabipleri Birliği, Türk Veteriner Hekimleri Birliği, and TÜRMOB,[5] organized a demonstration against the transfer of SSK hospitals to the Ministry of Health. Firstly they left a black wreath in front of the prime minister's office.[6] This demonstration, called the "Sosyal Devlet Sosyal Adalet Mitingi" (Social State Social Justice Rally), was organized on 20 November 2004. The Labor Platform stated in its press release that:

> It is asked that SSK health institutions be transferred to the Ministry of Health in a fait accompli. As mentioned in the Draft Law of Essential Principles of Public Administration (*Kamu Yönetimi Temel İlkeleri Kanun Tasarısı*), all health care units attached to the Ministry of Health are meant to be privatized. In that law, the Ministry of Labor and Social

3 "Devlet, herkesin hayatını, beden ve ruh sağlığı içinde sürdürmesini sağlamak; insan ve madde gücünde tasarruf ve verimi artırarak, işbirliğini gerçekleştirmek amacıyla sağlık kuruluşlarını tek elden planlayıp hizmet vermesini düzenler." "56th Article of the Turkish Constitution," https://www.tbmm.gov.tr/develop/owa/anayasa.uc?p1=56.

4 The draft of the law number 5283 "Bazı Kamu Kurum ve Kuruluşlarına ait Sağlık Birimlerinin Sağlık Bakanlığı'na Devredilmesine dair 5283 Sayılı Kanun," http://www2.tbmm.gov.tr/d22/1/1-0918.pdf.

5 Yıldırım Koç, *Emek Platformu,* (Ankara: Türk-İş Eğitim Yayınları, 2011) http://www.yildirimkoc.com.tr/usrfile/1322169805b.pdf.

6 "Emek Platformu SSKlar için Ankara'ya Gidiyor," BIANET, November 19, 2004, http://bianet.org/bianet/siyaset/48626-emek-platformu-ssklar-icin-ankaraya-gidiyor.

> Security is left outside of this practice. With the law regarding their transfer, it will become possible for SSK health institutions to be transferred to local governments. Briefly, as stated by government officials, health will not be gathered exclusively under the Ministry of Health but will be even more decentralized. The role of the Ministry of Health in this process as a sort of intermediary.[7]

The approach of the Labor Platform can be summarized as a concern over the eventual privatization of the SSK health units after their transfer to the Ministry of Health given the other draft law prepared for the reorganization of public administration.

Erdoğan responded to the demonstration of the Labor Platform by stating:

> By filling buses with people who are you bringing to where and with what type of funding? Wouldn't it be wiser to open a hospital or two with what has been spent on this event? I was also covered by SSK; I know what types of challenges you go through.[8]

Criticisms of the law regarding the transfer of SSK hospitals to the Ministry of Health, which also came from DİSK and the TTB, was supported in demonstrations organized by both. This issue is voiced by labor unions as well as the TTB because it impacted service receivers, namely workers with SSK coverage. The declaration of DİSK on this issue is also worthy of note even though the main emphasis was in line with what was stated by the Labor Platform of which it was part . The chairman of DİSK, Süleyman Çelebi, stated:

> Such an initiative by the government is against the constitution and infringes the law. The minister claims to centralize and regularize

7 "Emek Platformu Sosyal Devlet Sosyal Adalet Mitingi: 20 Kasım 2004," TMMOB, 11 November 2004, http://www.tmmob.org.tr/icerik/emek-platformu-sosyal-devlet-sosyal-adalet-mitingi-20-kasim-2004. (See appendix C.97 for the original.)

8 "Otobüsleri doldurup kimin parasıyla kimi nereye götürüyorsunuz. Onları oraya toplamak için yaptığınız masrafla bir iki hastane açsanız olmaz mıydı? Ben de SSK'lıydım. Ne çileler çekiyorsunuz bilirim." "Erdoğan'dan Emek Platformu'na Tepki," NTV, 20 November 2004, http://arsiv.ntv.com.tr/news/296977.asp?om=-21O.

> health services, but this is not true. The problem on the contrary, lies there. Most of the expenses of SSK hospitals are devoted to purchasing services. The purchase of services then becomes a mechanism of corruption. By sharing pension funds and selling health services, they are aiming to have higher profits.[9]

DİSK was a prominent actor voicing concerns over the transfer of SSK hospitals to the Ministry of Health as health care service receivers, who would be impacted by this transfer, were workers some of whom were represented by DİSK. The law draft that eventually passed through parliament on 19 January 2005 not only covered the transfer of SSK hospitals but also those of other public hospitals attached to public institutions, such as the State Railways. The main argument put forward by DİSK was the lack of a legal basis for the draft law. This was because the hospitals in question were established through premiums collected from workers with SSK coverage. A statement by Süleyman Çelebi two weeks before the law passed emphasizes this argument and their concern about the issue:

> With this law, SSK hospitals established exclusively by premiums paid by employers and employees, are demanded to be transferred to the Ministry of Health. SSK is an autonomous institution and its properties cannot be transferred by a political decision. The Ministry of Health committed an illegal act in sending a circular to the provincial governorships to prepare the necessary infrastructure for the transfer before the passing of this law. We will make a denunciation. Public hospitals to be transferred to the Ministry of Health will be transferred to local governments in the near future and eventually to the private sector. Public institutions will only be in a position to purchase health-care services, while the provision of health-care services will only be done by private health-care institutions. Under these circumstances, the right to health, which is a fundamental human right, will have a

9 "Disk: SSK Hastaneleri Devredilemez," BIANET, October 21, 2004, http://bianet.org/bianet/saglik/45658-disk-ssk-hastaneleri-devredilemez. (See appendix C.98 for the original.)

> price - in other words, be commodified -, and everyone will have the right to health in proportion to the money they possess.[10]

The Secretary General of SES Şükran Doğan also emphasizes that:

> SSK properties are under private law status. If the government plans to provide health services exclusively, then they need to transfer private hospitals to the Ministry of Health, too. "Kamu Yönetimi Temel Kanun Tasarısı" (Draft Law on Public Administration) projects the transfer of hospitals under Ministry of Health control to local administrations; in this way, SSK hospitals will also be part of the privatization that will take place in local administrations.[11]

The position of the TTB on this issue is in line with that of DİSK and the Labor Platform. Following the announcement of the draft law on the transfer of SSK hospitals to the Ministry of Health, the TTB immediately responded saying that this move would not only impact doctors working in those hospitals and citizens under the SSK coverage but everyone who lives in Turkey. In their immediate statement, the inconsistency of the discourse of the Ministry of Health to exclusively provide health services is also emphasized. On this issue, the deputy chair of TTB, Metin Bakkalcı, stated that

> the transfer of SSK hospitals is a turning point for the whole country. There is a power against us and a counter-power should emerge. We should form a power by uniting. After this point, asking the question "What is the situation?" makes no sense. The circumstances are obvious: SSK hospitals are being invaded and we should not allow this to happen. We should set up tents in front of SSK hospitals. We should say that we are not giving up on SSK hospitals. The SSK operation not only concerns workers and doctors but 70 million people. With the

10 "İşçiler SSK Devredilirse Üretimi Durduracak," BIANET, January 6, 2005, http://bianet.org/bianet/emek/52180-isciler-ssk-devredilirse-uretimi-durduracak. (See appendix C.99 for the original.)

11 "İşçiler SSK Devredilirse Üretimi Durduracak," BIANET, January 6, 2005, http://bianet.org/bianet/emek/52180-isciler-ssk-devredilirse-uretimi-durduracak. (See appendix C.100 for the original.)

> transfer of these hospitals to the Ministry of Health, the coefficients of premiums will rise from 5 to 12 percent, and the health service provided will not be the same as today. A minimum health service will be provided, and contribution payments will be taken from all other health-care services. Pensioners will pay an extra premium. Workers will receive health-care services in accordance with the amount of money they can pay. The SSK operation not only concerns doctors and workers but is the direct concern of all 70 million people.[12]

TTB general council member Dr. Altan Ayvaz added that:

> The Ministry of Health claims to exclusively provide health services. The TTB has argued for the same for years. But what is being done now is hypocritical because when the "Kamu Yönetimi Temel Kanunu" is passed, all hospitals will be transferred to provincial special administrations. Thus, health-care services will be divided into 81 pieces. Later, they will privatize and marketize those hospitals. If they are sincere about providing exclusive health care service, why did they not include military hospitals and private hospitals? What they aim for is not consistent with what they claim.[13]

Concerns over the eventual privatization of SSK hospitals following their transfer to the Ministry of Health is also accompanied by the question of whether the health-care services delivered in SSK hospitals would deteriorate following the transfer. Following the passage of the transfer law, Mustafa Sütlaş, a health rights activist who writes extensively on Turkish health-care sector issues, patients rights, and the HTP, argued that it would have consequences in addition to privatization in terms of, for instance, the deterioration of patients rights. The first day following the transfer, according to him, showed that there would be more violations of patients rights in the future as a consequence of this transfer since it was not really designed to gather health-

12 "Çadırlar Kurulmaya Başlanmalı." *Evrensel*, October 23, 2004. http://www.evrensel.net/haber/155552/cadirlar-kurulmaya-baslanmali. (See appendix C.101 for the original.)

13 "Çadırlar Kurulmaya Başlanmalı." *Evrensel*, October 23, 2004. http://www.evrensel.net/haber/155552/cadirlar-kurulmaya-baslanmali. (See appendix C.102 for the original.)

care services under one roof. He summarized his argument in the following statement:

> The aim is not to gather health-care services under a "single roof." The exclusion of certain public institutions and health-care institutions from this "single roof" clearly shows the actual ambition and intention. This becomes apparent with the limiting of referrals to superior centers for services that cannot be provided in health-care institutions attached to the Ministry of Health. With this regulation, the government obliges citizens with SSK coverage to go to *sağlık ocakları* (coomunity clinics), the main duty of which is neither diagnosis nor treatment, and the *sağlık ocakları* enforces referrals to public hospitals which are planned to be transferred to the private sector at the earliest opportunity. This will direct people with SSK coverage to private health-care institutions instead of superior public-health care units and thus prevent citizens under SSK coverage from reaching and fully benefiting from health services.[14]

The same concern is expressed by the Kartal Health Platform, which is composed of non-governmental organizations and unions in the areas of Kartal and Gebze.[15] Before the passage of the SSK hospitals transfer law, the real objective of the government was interpreted as the privatization of health-care services - an imposition of the IMF and the WB -, and this transfer was explained as the first step in an attempt to privatize.[16] Instead of the transfer, the

14 "SSK'nın Devri Hasta Hakkı İhlalini Arttıracak," BIANET, February 25, 2005, http://bianet.org/bianet/siyaset/55087-ssknin-devri-hasta-hakki-ihlalini-artiracak. (See appendix C.103 for the original.)

15 The components of the Kartal Health Platform are: Sağlık ve Sosyal Hizmet Emekçileri Sendikası (SES)Anadolu Yakası Şubesi, Türk Mühendis ve Mimar Odaları Birliği (TMMOB)Elektrik Mühendisleri Odası, Mimarlar Odası, Makine Mühendisleri Odası, Eğitim ve Bilim Emekçileri Sendikası (Eğitim-Sen), Türkiye Genel Hizmet İşçileri Sendikası (Genel-İş), Nakliye İşçileri Sendikası (Nakliyat-İş), Liman, Tersane Gemi Yapım-Onarım İşçileri Sendikası (Limter-İş), Türkiye Emekliler Sendikası (Emekli-Sen) ve Halkevi Aşağı Mahalle Şubesi.

16 "Sağlık Platformu'ndan SSK'ların Devrine Tepki," BIANET, January 12, 2005, http://bianet.org/bianet/saglik/52487-saglik-platformundan-ssklerin-devrine-tepki.

Kartal Sağlık Platform proposed the following steps to be made to improve health services:

> resources should not be allocated to the IMF and other interests but to health. The government should pay its 2 quadrillion debt to the SSK, the 4 quadrillion debt of employers to the SSK should be cashed in, all employees should have social security, investments should be made in SSK hospitals, service procurement from the private sector should be terminated, corruption in the SSK should be prevented, political appointments of staff should be terminated, all the work of the SSK should be open to public view, new SSK hospitals should be opened, [and] the SSK should be administered by its real possessors: workers or their representatives.[17]

The CHP also opposed the transfer of SSK hospitals to the Ministry of Health with similar concerns to those discussed previously. The criticism of the CHP emphasized how rapidly the government prepared the draft law concerning the transfer, and it considered this move to be more so a transfer of property rather than a reform of the health-care system. CHP members of parliament, by posing questions and demanding a quorum for decision processes, slowed the discussion of the law draft in the general assembly during its first session. Deniz Baykal, then the CHP leader, summarized their opposition in the following way:

> This is a property transfer regulation. It is against the constitution. It is explained in the constitution how an institution subject to private law can be transferred to public. This can be done via expropriation. This is de facto confiscation. But there is an effort to show this as if it were not a confiscation. This is seizure. This is against conscience, against the constitution, and against labor. It is extremely incorrect to pass such a significant regulation in a hurry. The matter, in reality, is to get

17 "Sağlık Platformu'ndan SSK'ların Devrine Tepki," BIANET, January 12, 2005, http://bianet.org/bianet/saglik/52487-saglik-platformundan-ssklerin-devrine-tepki. (See appendix C.104 for the original.)

rid of the responsibility of the state to provide services and to transfer this task first of all to local administrations.[18]

Opposition to the transfer law continued after the law passed and CHP appealed to the Constitutional Court for its annulment.[19] By a majority of votes, the annulment request was rejected by the Constitutional Court on 5 January 2005.[20] In February 2005, the transfer of SSK hospitals to the Ministry of Health started.

§ 7.2 Public Hospital Unions (Kamu Hastane Birlikleri)[21]

Public Hospitals Unions (Kamu Hastane Birlikleri) was another issue discussed by the TTB and other major unions and professional associations in the health sector as a step towards the commodification of health services. The issue was brought forward by the government in the "Draft Law on the Pilot Practice of Public Hospital Unions" (Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı) on 10 October 2007,[22] and the law came into

18 *Cumhuriyet.* "İşçinin Malı Gasp Ediliyor," January 6, 2005. (See appendix C.105 for the original.)

19 "Anayasa Mahkemesi SSK'nın Devrinin İptal İstemini Esastan Görüşecek," Medimagazin, February 10, 2005, http://www.medimagazin.com.tr/ana-sayfa//tr-anayasa-mahkemesi-ssknin-devrinin-iptal-istemini-esastan-gorusecek-1-666-249.html.

20 "Anayasa Mahkemesi Kararı - Bazı Kamu Kurum ve Kuruluşlarına ait Sağlık Birimlerinin Sağlık Bakanlığı'na Devredilmesine dair Kanun (5283)," TTB, March 19, 2010, https://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=749:anayasa-mahkemeskarari-bazi-kamu-kurum-ve-kuruluarina-a-saik-bler-saik-bakanlina-devredmese-da-kanun-5283-e-g&catid=24:belgeler&Itemid=41.

21 "The Public Hospital Unions" were annulled with the statutory decree no. 694 on 25 August 2017. The annulment is explained by Tükel as a consequence of the increasing debts of the Ministry of Health Hospitals indicated in the audit report of the Turkish Court of Accounts. After the annulment of the Public hospital Unions, "City Hospitals" (Şehir Hastaneleri) project was introduced which is based on public-private partnership. (Raşit Tükel, "Sağlıkta Dönüşümde Son Dönem: Şehir Hastaneleri," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 214.

22 "Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı," http://www2.tbmm.gov.tr/d23/1/1-0439.pdf.

force after being published in the Official Gazette on 2nd November 2011 within the enactment entitled "Statutory Decree on the Organization and Duties of Ministry of Health and its Dependent Institutions" (Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname).[23]

This law changed the organizational and administrative status of secondary and tertiary health institutions. The draft law proposed that upon the Ministry's proposal and final approval of the Council of Ministers, secondary and tertiary health institutions would be converted into "Public Health Associations," public entities still attached to the Ministry of Health. Depending on the scope and number of services provided, health units of more than one province could unite to form a single association or more than one association could be established in a province.[24]

The main emphasis of the Ministry of Health and the government in proposing the "Public Hospital Unions" was the autonomization of public health institutions. The preamble of the draft law stated:

> In our country during the twentieth century it can be observed that health care services have been significantly centralized. While in the first half of the twentieth century, most hospitals were administered by local administrations, in the second half of the twentieth century, health service provision has been centralized. Fast growth and centralizing the workload and processes related to health care services prevented the Ministry from focusing on its fundamental responsibilities. Infrastructural preparations to free the Ministry of Health of the workload burden that in reality needs to be handled by local administrations have been finished to a large extent. Public hospitals that used to serve under different public institutions have been gathered under one roof, and redundant use of public resources has been prevented. The

23 "Sağlık Hakkında Bazı Hükümler Hakkında Kanun Hükmünde Kararname, no: 663 http://www.mevzuat.gov.tr/MevzuatMetin/4.5.663.pdf "Sağlıkta Yeni Düzen Kamu Hastane Birlikleri Yasalaştı," TÜM-RAD-DER, last accessed December 12, 2016, http://www.tumrad.net/?Syf=26&Syz=68913.

24 "Kamu Hastaneleri Özerkleştiriliyor," Meclis Haber, March 18, 2010, http://www.meclishaber.gov.tr/develop/owa/haber_portal.aciklama?p1=98480.

> insufficiency and unbalanced distribution of health personnel have been dealt with, health personnel are subject to a system of appointment according to objective rules and needs, and the unbalanced distribution of health personnel has decreased to an acceptable level. Even the remotest places in the country are provided with health personnel. With the family physician model and community health centers, primary health care and preventive medicine have been reinforced. As these steps have been made within the framework of the HTP, we believe the time has come to transfer authorization and responsibility for decision-making over the provision of health services, income generation, and expenditures to autonomous public hospitals. With this draft law, we project the establishment of Public Hospital Unions. We aim to transform hospitals into unions that are responsible for their own resources instead of endlessly demanding personnel and material resources from the center.[25]

Reactions to the draft law emphasized that this new regulation was a step towards the privatization of health services and made profit the primary concern of health service institutions, instead of public health. Especially the administrative board as it was defined in the draft law was criticized. In the article regarding the establishment of the Public Hospital Unions, the administrative board of each *union* is defined in the following way:

> The units of the *union* are made up of an executive board, a general secretariat, and hospital administrations. The executive board is the highest decision-making body among these and is composed of: a member with a law degree to be determined by the Provincial Assembly (İl Genel Meclisi), a certified public accountant or tax professional to be determined by the Provincial Assembly, a member with a bachelors degree in Business Administration, Economics, or Accounting to be determined by the governor, a member with a medical degree to be determined by the Ministry, a member with experience in the health

25 "Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı," March 6, 2007 http://www2.tbmm.gov.tr/d23/1/1-0439.pdf. (See appendix C.188 for the original.)

> sector and higher education of at least four years in a relevant field to be determined by the Ministry of Health, a member with a four year bachelors degree to be determined by the Chamber of Commerce and Industry, [and] the Provincial Health Director or, if there is more than one *union* in a province, one of the vice provincial health directors to be determined by the Ministry.[26]

The composition of the executive boards of the *union*s were criticized on the grounds that they are composed mostly of non-medical professionals and appointed either by the Ministry of Health or by governors who are themselves appointed by the government. Thus, while the preamble of the law stated that the main reason behind the establishment of *unions* is to decentralize healthcare administration, it is actually further centralizing it.

During the demonstration, the Health Platform stated its criticism of the composition of union executive boards: "Hospitals will be administered by a 7-member board, the majority of which is chosen by the Provincial Assembly and the Chamber of Commerce [and is] susceptible to the intervention of politics and the market."[27]

The Istanbul Medical Chamber also responded to the composition of the executive boards of the unions, emphasizing that trade unions and NGOs are not included on the boards:

> Three members will be elected by the Ministry of Health, two by the provincial assembly, and one by the governor. But NGOs will not be forgotten. The seventh member is to be selected by the Chamber of Commerce. The universities, professional associations, unions etc.. in

26 "Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı," March 6, 2007, http://www2.tbmm.gov.tr/d23/1/1-0439.pdf. (See appendix C.189 for the original.)

27 "Hastaneler İl Genel Meclisi'nin ve İl Ticaret Odası'nın belirlediği yöneticilerini çoğunlukta olduğu, siyasal ve piyasa müdahalesine açık 7 kişilik kurul tarafından yönetilecek." "Kamu Hastane Birlikleri Yasası Ne Getirecek?" BIANET, April 6, 2010, http://bianet.org/bianet/siyaset/121138-kamu-hastane-birlikleri-yasasi-ne-getirecek.

> case they claim they are part of civil society, they would be invited to board meetings without the right to vote.[28]

The Secretary General of the TTB, Altan Ayaz, summarized their stance with respect to the Public Hospital Unions Law by underlining that the main principle of hospitals would become the generation of income, and the composition of the board of executives is an indicator of this:

> The HTP that is being executed by the Ministry of Health for more than 4 years aims to privatize public hospitals by making them work as businesses according to concerns for profit and loss. The 59th AKP government made numerous steps in this direction, and in this regard, with the draft law on the "Pilot Practice of Public Hospital Unions," it is planned that public hospitals to be gathered under one roof, that the administrative structure of the hospitals be fundamentally changed, and that the executive board members be determined by the governor, local authorities, the provincial special administration, and the chamber of commerce led by a secretary general. Public hospitals will be organized as associations and forced to be institutions set adrift with their own resources. The labor and salary regime is also changing. In short, public hospitals are being opened to the market.[29]

Not just the composition of the executive boards but the authority and responsibilities defined for them are also criticized with regards to changing the structure of hospitals. Public hospitals, it is argued, will not be institutions where the state provides health services but rather new institutions where those services become commodities through which profit is generated.

SES also expressed their concern that this change will transform hospitals into commercial institutions. The SES İzmir branch chair stated:

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28 "Kamu Hastane Birlikleri Yasa Tasarısına Dair," İstanbul Tabip Odası, August 25, 2010, http://istabip.org.tr/1376-kamu-hastane-brlkler-yasa-tasarisina-dar-.html. (See appendix C.163 for the original.)

29 "Kamu Hastaneleri İşletme Haline Geldi," *BirGün,* September 11 2007, http://www.birgun.net/haber-detay/kamu-hastaneleri-isletme-haline-geldi-35950.html. (See appendix C.106 for the original.)

> We as SES have long claimed that health should be designed and provided as a public service. The free, equal, accessible reception of health services by the public is a significant part of our argument. Our objective is that citizens who come to health units be treated as "patients" rather than as "clients" and that the units that provide primary and preventive care to citizens be called "public health units" instead of "businesses."[30]

The same concerns are also voiced by academics and activists whose studies and articles focus on Turkish health policy. Ata Soyer[31] explains the consequences of the public hospital unions following a report published by the Ministry of Health on the Ankara Numune Hastanesi dated 18 January 2010. Given the suggestions made by the Ministry of Health based on the analysis, Soyer points out that public hospitals would be viewed and managed as businesses rather than health units. The report stated that the number of patients per specialist MD is low, the expenditures of the hospital has increased from 2007 to 2009 while investment expenditures decreased, expenditure for medical equipment and medication increased, payment of workers for repairs and construction was more than 25 percent higher than the minimal wage, expenditures on electricity, water, and heating increased unrestrainedly, medicine stock check is not done properly and there is a surplus of 4-5 million lire worth of stock, and the ability to pay off debt is weak. As a consequence, what was proposed for this hospital was not make any investments through the revolving fund budget unless there was an emergency. The same report also states that for a neighborhood outpatient clinic project first a cost-benefit analysis should be conducted, the number of midwives and nurses should be increased, a cost-benefit analysis of the procurements of laboratory services should be conducted, the use of medical and laboratory supplies should be

30 "Sağlıkta Dönüşümde Maksat Ticaret," *BirGün,* April 2, 2010, http://www.birgun.net/haber-detay/saglikta-donusumde-maksat-ticaret-51914.html. (See appendix C.108 for the original.)

31 Ata Soyer was a radiologist and an activist who worked at different positions in Ankara Medical Chamber and TTB, he was among the group who initiated the "White demonstrations" of the TTB in 1989 and wrote extensively on health policy, Turkish health care sector until his passing in 2013.

brought under control, and other management costs cuts should be made where possible.[32]

Ata Soyer after mentioning this report, states:

> Here are the clues to how the new system will run with this new law. There is no need for further explanation as everything is obvious. But still, let me summarize: This place is not a health institution! It is foremost a business. It is not a business that allocates funds in its budget for investment; if needed, the state can do that! Additional units can be established in order to generate more income, but before that, all the automation systems should be organized. There is no need to keep a record of medical operations; it is enough to note which operation generated how much money. Because it is a business! The expenses for unnecessary things such as medications and medical supplies should be decreased to minimize costs. We should not employ more workers in order not to pay out more…[33]

§ 7.3 The State Budget and Health

The commodification of health care services were also discussed with respect to the financing of health care services. The TTB and other major actors contesting the HTP criticized the changing financial structure of the health care system and underlined how this new structure makes health care services more a commodity than a right of the people. They argue that, as services become harder to reach due to increasing dependence on purchasing power, these developments constitute a threat to peoples' health and to their access to health care services.

32 Ata Soyer, "Kamu Hastane Birlikleri Yasası'nın Getirecekleri," BIANET, March 18, 2010, http://bianet.org/bianet/siyaset/120734-kamu-hastane-birlikleri-yasasi-nin-getirecekleri.

33 Ata Soyer, "Kamu Hastane Birlikleri Yasası'nın Getirecekleri," BIANET, March 18, 2010, http://bianet.org/bianet/siyaset/120734-kamu-hastane-birlikleri-yasasi-nin-getirecekleri. (See appendix C.109 for the original.)

The discussion of criticisms of health care service financing in this subsection will focus on pharmaceutical policies: both the increased import of pharmaceuticals and the decreasing coverage of medicines in the social security schemes.

The TTB and other actors contesting the HTP were critical of policies that reorganized the production, prescription, import-export, and purchase of pharmaceuticals. In this subsection, these criticisms will be discussed through three issues. Firstly, discussions of the Tedavi Yardımına İlişkin Uygulama Tebliği (Communiqué on the Execution of Aid for Treatment), which reorganized the prescription of medicine and the categories of medicine covered by social security schemes will be analyzed. Secondly, criticisms of the Kamu İlaç Alım Protokolü *(*Public Pharmaceutical Purchase Protocol) that organized the transaction of medicines between the social security institutions and pharmacies will be discussed. And lastly, the views of the TTB and other constituents of the opposition on pharmaceutical expenditures in Turkey, their proportion to health expenditures, and the percentage of imported medicines in the Turkish market will be discussed.

The Tedavi Yardımına İlişkin Uygulama Tebliği was initially published in the official gazette on 29 April 2006, and the last version was published on 10 December 2009 by the Ministry of Finance. The communiqué aimed to ensure a common practice among institutions regarding the price of treatments received by the beneficiaries in health institutions and to determine the criteria and procedures for payment.[34]

The communiqué stated that specialist doctors can only prescribe medicines related to their specializations, and family physicians can only prescribe authorized medicines. The TTB objected to this regulation as they claimed that patients do not have equal access to specialists in all parts of the country. In January 2006, the foundation for this communiqué regarding prescription

34 "Bu Tebliğin amacı; kapsama dahil hak sahiplerinin sağlık kurum ve kuruluşlarında yapılan tedavilerine ait ücretler ile tedavi yardımına ilişkin işlemlerde, kurumlararası uygulama birliğinin sağlanması, geri ödeme kriterlerinin ve bunlara ilişkin esas ve usullerin tespit edilmesidir." "Tedavi Yardımına İlişkin Uygulama Tebliği," April 29, 2006, http://www.mevzuat.gov.tr/Metin.Aspx?MevzuatKod=9.5.10237&MevzuatIliski=0&sourceXmlSearch=tedavi%20yard%C4%B1m%C4%B1na%20ili%C5%9Fkin%20uygulama%20tebli%C4%9Fi.

medicines was published in the framework of an "Instruction on Budget Implementation." According to this instruction almost 1000 widely-used medicines became restricted and were to be prescribed only by specialist doctors. Following the implementation of this practice, in a survey conducted by the website doktoruz.com - an online platform that brings together general practitioners and specialists in forums to exchange views on legal and medical issues concerning their profession- 79 percent of participants thought that patients have difficulty accessing specialist doctors and 62 percent were not convinced that the measures introduced by the government would result in decreased expenditures.[35]

Both pharmacists and patients voiced their objections to the "Communiqué on Tasarruf Tedbirleri" which was put into practice on 1 August 2006. According to this communiqué, certain medicines such as vitamins, flu medications, and some medicines used for the treatment of obesity were removed by the Ministry of Health from the list of medicines covered by the social security schemes. A patient interviewed on this issue stated that: "We already had difficulties accessing health services, and these new measures are a move towards a dead end. The state not paying for medicines that are frequently used in winter against the flu shows the position of the state exactly."[36]

The difficulty of accessing certain medicines in the market were also underlined together with the exclusion of certain medicines from coverage by the state. The chair of the Izmir branch of SES stated that:

> Hundreds of patients are on the verge of death because they cannot find immunoglobin. Recently, 19-year-old Rukiye Elmacı died because of this. The IMF makes demands, and the government stops paying for the medicines. Cough syrups, medicines for the flu, vitamins, medicines for osteoporosis, medicines for obesity, x-ray medicines, and some cancer treatment medicines have been taken off the list of med-

35 "Hasta Uzman Hekime Erişemiyor," *Cumhuriyet,* April 28, 2006, 7.

36 "Sağlıkta Tasarruf Olmaz," *Cumhuriyet,* July 11, 2006, 5.

> icines covered. The health policies of the government will result in destruction and 8.5 million people died in countries where similar health policies were adopted.[37]

The discussion triggered by the publication of the communiqué also focused on possible consequences in terms of both public health and exclusion of certain medicines from the list of medicines covered by social security. Concerns over public health and the increasing prices of medicines go hand in hand in these critiques.

The chairman of the Türkiye Eczacılar Birliği voiced his view on this subject after the publication of the communiqué:

> With this communiqué, the coverage for vitamins for children, the elderly and pregnant women has been ended. Not one single vitamin is included in the list of medicines covered. Additionally, medicines used for treatment of obesity, which is becoming a more and more widespread illness in Turkey, have been taken off the list of medicines covered by the state. These medicines not being on the list will result in these patients being vulnerable to serious, chronic illnesses such as hypertension, cardiac failure, high cholesterol, and diabetes. Thus, the treatments required for these illnesses will increase costs.[38]

The main argument of opponents are an increase in chronic diseases and more people needing treatment. This concern, as mentioned above, is paired with concern about rising costs due to the need for treatment.

The Chair of the Istanbul Chamber of Pharmacists stated that:

> the results of the new practices are not good. It started with the limitation on doctors for the prescription of medicines; later on, certain medicines were removed from the list of medicines covered by social

37 "SES: Hayati İlaçlar Bulunamıyor, Kaanlar Rukiyeler Ölüyor," *BirGün,* November 15, 2006. http://www.birgun.net/haber-detay/ses-hayati-ilaclar-bulunamiyor-kaanlar-rukiyeler-oluyor-29982.html. (See appendix C.111 for the original.)

38 "Kronik Hastalıklara Davetiye Çıkarıyorlar," *BirGün,* July 13, 2006. http://www.birgun.net/haber-detay/kronik-hastaliklara-davetiye-cikariyorlar-27952.html. (See appendix C.112 for the original.)

> security schemes; recently, they are proposing a practice whereby medicines that cost 1-2 lire be sold without a prescription. Thus, the prices of these medicines will rise. Transformation in Health is a transformation towards liberalization. From the beginning of the implementation of this program, pharmaceutical expenses have risen by 44 percent. We have become the fastest-growing pharmaceutical market, and by 2010 we will be among the largest 10 pharmaceutical markets.[39]

The second issue raised on pharmaceutical policies concerns the Kamu İlaç Alım Protokolü introduced by the government in January 2007. This protocol was introduced following the transfer of SSK hospitals to the Ministry of Health and regulated how pharmacists contracted with the social security schemes would carry out the delivery of medicines, the procedures that need to be followed regarding prescriptions, and how pharmaceutical purchases and refunds would be done by the social security schemes.

Among the main objections, the one most highlighted is the payment schedules for medicines sold by pharmacists to patients with social security coverage. According to the protocol, after the delivery of medicines to patients the social security institution has 75 days to pay the pharmacists.[40]

Apart from planned regulations to ease the sale of certain pharmaceuticals in supermarkets, the payment schedule introduced resulted in protests by pharmacists. Their main concern was that they have to pay pharmaceutical warehouses immediately but would be paid by social security institutions only after 75 days, which they claimed would lead to the bankruptcy of many pharmacies. Additionally, the sale of certain medicines in supermarkets would bring an end to their profession.

In order to show their general reaction to AKP health policies and to the "kamu ilaç alım protokolü" (public pharmaceutical purchase protocol) introduced into the pharmaceutical sector in particular, the Istanbul Chamber of Pharmacists organized a demonstration on 14 January 2007. Beforehand, the

39 "Türkiye Sağlıkta Dönüşüm Problemi Yaşıyor," *Cumhuriyet,* December 7, 2006. 5. (See appendix C.190 for the original.)

40 "2007 İlaç Alım Protokolü Taslağının Tam Metni," Eczacının Sesi, October 13, 2006, http://eczacininsesi.com/?yon=haber&id=328.

chamber declared why they objected to the public pharmaceutical purchase protocol in particular and the health policies of the AKP in general:

> The laws that are brought in by the government as a consequence of the impositions of the IMF, the regulations that favor the pharmaceutical and distribution monopolies, and the price decrees on medicines exhaust the professional benefits of pharmacists. Bank loans are taken out by pharmacists as a consequence of payments not being made on time by the state; unjust stoppages quickly consume the finances of pharmacies. The new public pharmaceutical purchase protocol was organized as a unilateral contract and was presented to pharmacists as a slave contract. The payment in advance practice which forces pharmacies to accept payments from the social security institution (SGK) 75 days later will leave pharmacies in a difficult condition and eventually lead to bankruptcies.[41]

As stated by the Istanbul Chamber of Pharmacists, the emphasis is on the fact that regulations of pharmaceutical sales are being changed in favor of pharmaceutical companies and do not benefit their profession. During the demonstration organized by the Istanbul Chamber of Pharmacists, the chair of the chamber Zafer Kaplan, stated that:

> Pharmacists cannot get recompensed for their work. We are gathered here not only to draw attention to the problems of pharmacists but to the health problems of society. With the medicine price decree published in 2004, the share of pharmacists decreased; while producers and distributors in the pharmaceutical sector make a profit, it causes losses for pharmacists and the public. The laws of the government, the regulations introduced that benefit only the pharmaceutical industry and the delivery monopolies, and the rigid sales conditions imposed

41 "Eczacılar 14 Ocak'ta Kadıköy'de Toplanıyor," *BIANET*, January 10, 2007, http://bianet.org/bianet/saglik/90075-eczacilar-14-ocakta-kadikoyde-toplaniyor. (See appendix C.113 for the original.)

> by pharmaceutical warehouses have brought pharmacists to an economic deadlock, and we are here to protest this.[42]

The main concern voiced by the Istanbul Chamber of Pharmacists is the eventual economic crisis pharmacists will face. The claims of the Ministry of Health that the medical expenses of the SSK –thus the medical expenses of the country- would decrease as a consequence of closing down SSK pharmacies and instituting contracts with free-market pharmacies is objected to by both the Tıp Kurumu (Medical Institution) and the Istanbul Chamber of Pharmacists. The secretary general of the Medical Institution, Ali Üçer, stated that:

> We listed our projections two years ago with pharmacists in our report entitled "İlaçtaki Ur: Dışa Bağımlılık Raporu" (The Tumor in Pharmaceuticals: Foreign Dependency Report)[43] which were as follows: With the new system social security institutions will delay or completely stop repayments to pharmacies. This is a concern for pharmacies that make short-term purchases from pharmaceutical warehouses as they risk economic crisis and going bankrupt. The pharmacies that avoid bankruptcy will either stop providing medicines through the social security schemes or have difficulties doing so. Small-scale pharmaceutical warehouses and pharmacies will suffer losses and 5-10 thousand pharmacies will risk bankruptcy. The Kamu İlaç Alım Protokolü is part of a global plan and an operation of trans-national corporations. After the closing down of pharmacies, the sale of medicines in shopping malls will be widespread like in Western countries. This will add to the profits of pharmaceutical monopolies. Expenses on medicine in Turkey will increase by 3 billion US dollars in 2005, and this sum will be

42 "Eczacılar Hükumet Politikalarına Karşı Yürüdü" BIANET, January 15, 2007. http://bianet.org/bianet/siyaset/90212-eczacilar-hukumet-politikalarina-karsi-yurudu. (See appendix C.114 for the original.)

43 In the cited report, the reasons of the possible economic crisis that await the pharmacies are explained through cases and simulations: "İlaçtaki Ur: Dışa Bağımlılık," Tıp Kurumu and Ankara Chamber of Commerce, May 2005.

> transferred to multinational pharmaceutical companies. Turkey will lose and the multinationals will win.[44]

The third issue raised with respect to the pharmaceutical sector is increasing expenses. Even though the increase in expenses was a concern with the Kamu İlaç Alım Protokolü, the increased price of medicines, the increased spending resulting from this price increase, and how these increases are criticized is worth mentioning.

An investigation was initiated by the Istanbul Chief Public Prosecutor's Office into certain pharmaceutical companies and SSK bidding commissions that applied different quotations for certain medicines which resulted in systematic excessive payments by the state. The medicine in question was Neo-Recormon, a biological medicine whose active agent is Eritropoietin.[45] One of the main criticisms on this issue was dependency on foreign pharmaceutical companies for medicines despite the possibility of local production. On this issue, CHP member of parliament Mehmet Neşşar stated:

> The 'eritropoietin' which was the subject of corruption and for which a very high price is paid is produced at METU, but because of the indifference of the Ministry of Health, it is not licensed. Even though there is no international obstacle to the licensing of 'biological medicines', whose share in the 8.5 billion dollar pharmaceutical market is increasing day by day, the Ministry of Health remains indifferent to the licensing. A two-to-three-million-dollar investment would be sufficient for the production of this medicine in Turkey. If the Minister of Health is speaking of real transformation and change, he should pay more attention to the advice of prominent biotechnology and genetic scientists in this country instead of to the bosses of multinational pharmaceutical companies.[46]

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44 "Eczacı Faiz Sarmalında." *Cumhuriyet*, January 16, 2007, 12. (See appendix C.191 for the original.)

45 "Roche ve SSK Yolsuzluğu Hakkında Basın Açıklaması," Sendika Org, February 22, 2005. http://sendika63.org/2005/02/ito-roche-ve-ssk-yolsuzlugu-hakkinda-basin-aciklamasi/.

46 "Bu sorunun Tedavisi Yok mu?" *BirGün,* May 14, 2006, http://www.birgun.net/haber-detay/bu-sorunun-tedavisi-yok-mu-26938.html. (See appendix C.116 for the original.)

Criticism of the Ministry of Health by the professional associations and unions increased when claims that 29 companies sold overpriced medicines to the SSK and the Ministry of Health became public in the Prime Ministry Audit Report. In the report it is stated that these companies sold medicines to the SSK at much higher prices than on the international market. On this issue, chairman of SES Köksal Aydın stated that:

> The audit mechanism of the Ministry of Health is not functioning properly. The HTP is a program of corruption. It is handing health over to the private sector and paving the way for corruption. While the IMF is intervening in the health sector, the government is protecting dominant figures in the market. They are paving the way for corruption in health.[47]

In sum, the pharmaceutical policies of the Ministry of Health were criticized by professional associations and unions with respect to different issues such as the future of pharmacies, decreasing coverage, and vulnerability to corruption. These issues converge on the argument that profit making through medicine was prioritized over access to medicine and that health was commodified through this domain of health care.

§ 7.4 Concluding Remarks

To conclude, this chapter discussed the anti-reform discourse concerning the HTP. As the chapter highlighted, professional associations and trade unions led by the TTB gathered together to construct this anti-reform discourse and stressed that the HTP would lead to changes that would both deteriorate working conditions for doctors and health personnel as well as diminish citizens' right to health. Both concerns converged in an argument that the HTP would pave the way for a profit-oriented health care system wherein doctors and health personnel would be expected to generate more income for the institutions for which they work. In the long run of such a system, the contesters

47 "Hastane Kapalı, İlaç Pahalı," *BirGün,* June 18, 2006, http://www.birgun.net/haber-detay/hastane-kapali-ilac-pahali-27441.html. (See appendix C.117 for the original.)

argued, people will not receive services as a right but will rather have to access to it only as a commodity in the market. In other words, criticisms made by contesting actors underlined that the AKP's health policy reforms would lead to the commodification of health care services in the long run, and this would negatively impact both health-care receivers and health-care providers. The chapter traced the ways in which this line of criticism emerged through specific issues such as the transfer of SSK hospitals to the Ministry of Health, Public Hospital Unions, the changes to pharmaceuticals covered by social security schemes, increases in copayments, and budgetary changes introduced to the health sector by the AKP governments.

The next chapter deals with how the TTB responded to specific issues with the health transformation program in two parts. The first part deals with the concerns of the TTB about the loss of the health rights of the people as a consequence of health reform, and the second part discusses arguments that it foregrounded on the impact of health reform on the working conditions of health sector employees.

8

Highlighting the HTP's Negative Impacts on Health Care Providers and Health Care Receivers

The first two chapters of Part 3 "Contesting the health reform" focused on presenting who are the critics of the HTP, in what ways they differentiated the HTP from other health care reform attempts in Turkey, how they positioned their opposition to HTP within an overall stance in relation to health policy matters in the country. Chapter 7, demonstrates how the criticisms of the opponents converge on the argument that the long-term consequences of the HTP would be the privatization and commercialization of health.

This chapter, the concluding chapter of Part 3, looks at how according to the contesters the HTP impacts health care receivers and the working conditions of the health care providers through specific issues. In other words, this chapter demonstrates the results of the HTP according to the contesters. The first section presents the concerns of the contesters about the health rights of the people through epidemics and infant mortality. The second section discusses, the adverse impacts of HTP on the working conditions of the health care providers through issues such as full-time employment law, violence towards doctors, the introduction of the compulsory service, and the family practitioner model.

§ 8.1 Concerns over Citizens' Right to Health

Changes in the health care system as a consequence of the HTP that result in difficulties for citizens to access health services or having to pay for services for which they did not have to pay before are subjects that emerge frequently in the discourses of the TTB. This subsection discusses those concerns through epidemic diseases and infant mortality.

The approach of the Ministry of Health to epidemic diseases and maternal and infant care is criticized by the TTB. The main argument of these criticisms is that the weakening of primary health care services due to various steps made by the government (such as closure of the sağlık ocakları (community clinics) , decreases in investment in public health care units, and increases in the working hours of doctors which caused a decline in quality) paved the way for epidemic episodes, especially in rural areas. In this subsection, the arguments developed by the TTB with respect to three cases will be discussed.

A cholera outbreak in Ankara and Doğubeyazıt took place in late August 2005. 120 people received treatment for cholera in hospitals in Ankara, and more than 2000 went to hospitals complaining of diarrhea. The primary criticism made by the TTB and SES was that the Ministry of Health denied that this was an outbreak of cholera, and they invited the Minister to explain the case. The initial declarations of the SES focus on their analysis of the drinking water in Doğubeyazıt based on samples taken from nineteen locations.[1]

On this issue, Metin Bakkalcı, then Vice Chair of the TTB, stated that:

> It is purely by chance that the number of infected people is limited. The minister should first of all inform and clarify the claims made about this epidemic. There is a problem of having a command of the issue. We have encountered this problem in Doğubayazıt.[2]

Other critics focused on the argument that this and similar cases were a consequence of the marketization undertaken by the government through the

1 "Kolera Salgını Örtbas mı Ediliyor?" *BirGün,* August 24, 2005, http://www.birgun.net/haber-detay/kolera-salgini-ortbas-mi-ediliyor-24073.html.

2 "Kolera Salgını Örtbas mı Ediliyor?" *BirGün,* August 24, 2005, http://www.birgun.net/haber-detay/kolera-salgini-ortbas-mi-ediliyor-24073.html. (See appendix C.164 for the original.)

HTP. CHP group Deputy Chairman Haluk Koç, speaking on the issue of cholera, said:

> This is evidence of collapse in the health system. There are almost 100 ostensible cholera cases in Ankara but the Ministry remains silent. If you try to marketize health and even call it a "revolution in health," this can only be a counterrevolution.[3]

A similar criticism was made by Köksal Aydın, then chair of the SES. He stressed that the Ministry of Health did not sufficiently prioritize preventive health care services and thus risked the health of the people. He stated that:

> Marketized health services are part of privatization policies. Preventive health care services - in other words primary health care services - are the responsibility of a social state. The AKP forgets that duty and they leave the whole system to the market and try to establish a system where people get ill and need treatment.[4]

The declarations made following the cholera outbreak underlined that the symptoms of an outbreak were present, but the Ministry did not make the steps necessary to prevent epidemics. The declaration of Malatya Chamber of Civil Engineers exemplifies these declarations. The chamber focused on how they conducted analyses of the city's water supply and took samples from 133 different points starting in April 2005. Twelve sources were not suitable for use. In June this number increased to 38, in July to 42, and in August to 62. The report stated that the percentage of pollutants in the water rose from 9% in April to 21% in September 2005. The TTB stated:

> It was obvious that the epidemic was being caused by city water since April, but local authorities were not willing to cooperate. The HTP ex-

3 "Kolera İddiası Var Bakandan Çıt Yok" *BirGün,* August 5, 2005, http://www.birgun.net/haber-detay/kolera-iddiasi-var-bakan-dan-cit-yok-23867.html. (See appendix C.118 for the original.)

4 "Salgın Hastalık Pençesi," *BirGün,* August 26, 2005, http://www.birgun.net/haber-detay/salgin-hastalik-pencesi-24101.html. (See appendix C.119 for the original.)

> ecuted by the Ministry of Health abolished work on public and environmental health, and in the current case, the incubation time for typhoid and hepatitis B still continues.[5]

The actors that opposed the HTP in particular and the policies of the Ministry of Health in general emphasized that cholera epidemics and the risk of other epidemic diseases were the direct result of the changing priorities of the Ministry, which resulted in less importance placed on primary health care services and public health. A statement of then President of SES, Köksal Aydın, summarized the arguments of actors in the health sector who shared the TTB's position:

> The mentality of marketizing health should change. Policies on health are more important to us than people. This country has been administered by IMF directives for 20 years. Work on this intensified during the AKP government and [under] Minister of Health Akdağ. The HTP is a concrete consequence of this process. A sufficient budget should be allocated to health from the overall budget. If they are not willing to do this, they have no right to be in those offices. They should either find solutions to the problems of the country or leave the offices.[6]

A bird flu outbreak that took place in January 2006 and the following months was an issue on which the position of the Ministry of Health was widely criticized by the TTB and unions that shared the same position in terms of health policies. The main difference between the bird flu and cholera is that geographically it was an international issue on which the WHO made official statements and published reports. It did not only impact Turkey. Thus, the views expressed in response to this outbreak by the TTB in reaction to the

5 "Salgın Bağıra Bağıra Gelmiş," *BirGün,* December 10, 2005. http://www.birgun.net/haber-detay/salgin-bagira-bagira-gelmis-25290.html. (See appendix C.120 for the original.)

6 "Kolera İddiası Var Bakandan Çıt Yok," *BirGün,* August 5, 2005, http://www.birgun.net/haber-detay/kolera-iddiasi-var-bakan-dan-cit-yok-23867.html. (See appendix C.121 for the original.)

attitude of the Ministry of Health are significant for understanding the position and discourse of the TTB on public health issues and how it differentiates itself from the Ministry of Health.

The WHO issued official warnings about bird flu (H5N1 avian influenza) throughout the world starting in late 2003. In October 2005, the WHO published a guide for member countries experiencing their first outbreaks of H5N1 avian influenza.[7] According to the official publication of the WHO, the first H5N1 was reported in poultry in Turkey in October 2005 and the first two human cases were reported in January 2006.[8]

The European Commission confirmed that the virus observed in Turkey is subtype H1N5, which is lethal in human beings, and it prolonged a ban on the import of poultry from Turkey until April 2006.[9]

The General Director of Basic Health Services at the Ministry of Health opposed this official statement of the European Commission stating that:

> For the moment there is no modification in the virus. It is unknown whether such an outbreak would take place or not. The current situation in our country has nothing to do with the aforementioned outbreak. In the first place, protective treatment has been carried out for 8 people. We stepped in [to tackle] the bird flu case in Manyas in a

7 "WHO guidance on public health measures in countries experiencing their first outbreaks of H5N1 avian influenza," WHO, October 2005, http://www.who.int/influenza/resources/documents/guidance_publichealthmeasures_h5n1_10_2005/en/. For further information also see "Review of latest available evidence on potential transmission of avian influenza (H5N1) through water and sewage and ways to reduce the risks to human health," WHO, October 2007, http://www.who.int/water_sanitation_health/resources/h5n1background.pdf?ua=1.

8 "H5N1 Avian Influenza Timeline of Major Events," WHO, December 2004, http://www.who.int/influenza/human_animal_interface/H5N1_avian_influenza_update200412.pdf?ua=1.

9 "Türkiye'deki Kuş Gribi Virüsü Ölümcül," *BIANET*, October 13, 2005. https://bianet.org/bianet/saglik/68685-turkiyedeki-kus-gribi-virusu-olumcul.

> rapid, precise manner. We have a sufficient stock of medicine for prevention and treatment. There is no need for rush and panic.[10]

The Minister of Health Recep Akdağ also emphasized that the bird flu is not a threat as portrayed. He stated that:

> An issue which is not actually on the agenda is being discussed. Will it happen again? It can happen in all the countries in the world, thus it can happen in Turkey, too. If it happens again, the precautions that we have taken will be repeated. But for the moment we have to take this issue off our agenda.[11]

The approach of the ministry and government was heavily criticized by the TTB and SES which argued that the Ministry's approach led to loss of life and greater spread of the virus due to the lack of information provided to the people. The spread of the virus and the cases that resulted in deaths of patients were interpreted as consequences of the HTP and inequalities in the health care system. Köksal Aydın, then leader of the labor union SES, stated that: "People are victims of regional inequality and the HTP politically." He added:

> As opposed to the healthy approach embraced in Balıkesir, in Iğdır the intervention for the bird flu took too long and we are disappointed. The fact that the Ministry made an announcement in Iğdır two days late brings to mind the possibility that during that period of time the virus may have contaminated thousands of people. This is a highly negative development for public health. The precautions taken in Manyas were not taken in Iğdır, and the medical intervention was delayed in Van due to lack of medical equipment in the hospitals, the absence of an obligation imposed on pharmacies to keep certain kinds

10 "Türkiye'deki Kuş Gribi Virüsü Ölümcül," BIANET, October 13, 2005. https://bianet.org/bianet/saglik/68685-turkiyedeki-kus-gribi-virusu-olumcul. (See appendix C.165 for the original.)

11 "Kuş Gribi AB Gündeminde, Bakan Unutalım Diyor," BIANET, October 18, 2005, https://bianet.org/bianet/saglik/68964-kus-gribi-ab-gundeminde-bakan-unutalim-diyor. (See appendix C.166 for the original.)

> of medicines in stock, and the lack of health personnel in the east. This has to do with the chronic cumbersomeness of politics, the consequences of the HTP, health not being a priority over economic interests, and the east being considered secondary in terms of health services like it is in other areas.[12]

In line with the points made by Köksal Aydın, Halkevleri (People's Houses) chairperson Abdullah Aydın stated that: "The real disaster facing our people is not bird flu but the commercial politics that the AKP proudly defends. The hospitals in the region, which are already insufficient in number, remained helpless when faced with bird flu. The government should resign."[13]

The TTB focused on the lack of precautions taken by the government despite the presence of a course of action prepared by the WHO. Metin Bakkalcı stated that:

> It is irresponsible that no measures were taken until the first death from bird flu. As a consequence of health policies embraced by the government, preventive health care services and veterinary services have notably collapsed. It is impossible to solve the problems through buying services; this process could not be managed at all.[14]

The TTB was also critical of the Ministry of Health for its approach following the first bird flu death. According to them, the approach of the Ministry and the government focused less on taking precautions than on trying to cover up mistakes:

12 "SES Sağlık Bakanlığı'nı Geç Kalmakla Suçluyor," *BIANET*, January 5, 2006, https://bianet.org/bianet/saglik/73079-ses-saglik-bakanligini-gec-kalmakla-sucluyor. (See appendix C.122 for the original.)

13 "AKP Kuş Gribinden Beter," *BirGün,* January 8, 2006. http://www.birgun.net/haber-detay/akp-kus-gribinden-beter-25617.html. (See appendix C.167 for the original.)

14 "Tüm Önlemler Alınmadı," *BirGün,* January 19, 2006, http://www.birgun.net/haber-detay/tum-onlemler-alinmadi-25714.html. (See appendix C.123 for the original.)

> What is real and more important is that after that day –when the first death from the flu took place- the rush to cover up shortcomings dominated the process. Despite the accumulation of experience in both the world and Turkey in this area, instead of realizing the necessities of a realistic action plan, there was a rush by the government to have immediate results, that caused anxiety for the future of our country and citizens.[15]

The spread of the virus and the deadly cases of bird flu were explained by the TTB and other opposers as a consequence of health policies embraced by the AKP rather than being unique, isolated cases.

Erhan Nalçacı, who wrote a book on the bird flu together with Aslıhan Çakaloğlu, stressed how the privatization of health services not only in Turkey but around the world impacted the spread of the virus, together with the approach of pharmaceutical companies that prioritized maximizing profits rather than reaching the maximum number of people. During an interview following the launch of the book he coauthored entitled "Kuş Gribi: Neden Tehlikeli? Nasıl Korunmalı?" (Bird Flu: Why Dangerous? How to Protect from it?)[16] he underlined that a series of structural changes taking place in the health system and steps not made during the first phases of the bird flu brought about the lethal consequences. Nalçacı stated that:

> The health policies of the government are not public-friendly because they are inclined towards privatization. The tendency to privatization has downgraded public health services, which have also been affected indirectly by pharmaceutical companies. We are learning only now that mass deaths of poultry took place in Eastern Anatolia. It was 4 January when these were made public. They are still inclined to hide the deaths that resulted from bird flu. They should have never kept this a secret. The public should have been informed and everyone should

15 "Almadıkları Önlemi Halktan Bekliyorlar," *BirGün,* January 23, 2006. http://www.birgun.net/haber-detay/almadiklari-onlemi-halktan-bekliyorlar-25778.html. (See appendix C.124 for the original.)

16 Erhan Nalçacı and Aslıhan Çakaloğlu, *Kuş Gribi Neden Tehlikeli? Nasıl Korunmalı?* (Ankara: Nazım Kitaplığı, 2006)

> be prepared. Turkey is long the route of migratory birds, but with this information in hand the government did not act until later on. There are also steps made that make us think there are problems of scientific methodology. The closure of the institute in Manisa due to costs, the president of Hıfzısıhha departing on a pilgrimage to Mecca during this outbreak crisis, and no precautions being taken for the transportation of animals during and before Eid-al-Adha.[17]

A different line of criticism focused on the impact of the government's steps to set their own cadres up in public offices. The example given is the appointment of a single person to three positions in public health institutions, namely the General Director of the Refik Saydam Hıfzısıhha Institute,[18] Turan Arslan, who was at the same time the chief of medicine at Şişli Etfal Hospital in Istanbul and chair of the Infectious Diseases Department at Zonguldak Karaelmas University. In response, then Chair of SES Köksal Aydın declared:

> How can you explain one person being appointed to three crucial administrative positions in three different provinces other than by the intention of setting up one's own cadres in public offices? The Hıfzısıhha Institute wanted to keep the cholera outbreak that took place in Ankara this summer a secret. In the same manner, the Hıfzısıhha Institute did not pass the test with its approach toward the bird flu case. Unfortunately, the Ministry appoints people that are close

17 "Kuş Gribi Sağlığa Erişim Hakkı Sorunu," BİANET, January 23, 2006, https://bianet.org/bianet/saglik/73702-kus-gribi-sagliga-erisim-hakki-sorunu. (See appendix C.125 for the original.)

18 Refik Saydam Hıfzısıhha Center used to run the services of public health and preventive medicine. It had the responsibility of producing various vaccinations and serums, antigens, antiserums, evaluating the pharmeucitical impacts of medicines with and without license. It is transferred to Turkey Public Health Institute with a statuary decree dated 02.11.2011. Following this development with the decree of Turkey Public Health Institute in 81 provinces of Turkey public health directorates are established and public health labaratories are founded associated to them. "İstanbul 1 No'lu Halk Sağlığı Labaratuarı'nın Tarihçesi," İstanbul İl Sağlık Müdürlüğü, last accessed 01 March 2018. http://www.istanbulhalksagligi.gov.tr/ozel-sayfa/1-nolu-halk-sagligi-laboratuvari/kurumsal-yapi/tarihce.

> to them politically to significant positions in public offices. These appointments prevent health institutions from making necessary interventions in cases that require knowledge, expertise, and experience. Another reason for the frequent outbreaks is that preventive health care services are neglected. A committee has been set up by the Ministry following the outbreak in October, but no further information has been provided to the public on what has been done by this committee.[19]

Following the cases of cholera and bird flu, opponents of health reform such as the TTB and SES interpreted the lethal consequences of these epidemic outbreaks as result of the health policies embraced by the government that undermined primary and preventative health care services. They also highlighted appointments to administrative positions in health institutions based not on qualifications and merit but on proximity to the political networks of the government. These two cases and how they were interpreted by those contesting health reform are discussed in this subsection to demonstrate how concern for the health rights of citizens arose in the arguments of the TTB as they criticized health policies embraced by the government.

§ 8.2 Working Conditions of Doctors and Health Personnel

Especially in the second half of the 2002-2011 period, the discourses of the TTB concentrate on the impacts of the HTP on the working conditions of health personnel, particularly doctors. The objections made by the TTB in this respect will be analyzed through the "tam gün yasası" (full time employment law), violence towards doctors, and introduction of the family practitioner model.

19 "Tehlikenin Boyutları Ciddi," *BirGün,* January 8, 2006, http://www.birgun.net/haber-detay/tehlikenin-boyutlari-ciddi-25614.html. (See appendix C.127 for the original.)

8.2.1 *Full-time Employment Law*

The draft law known as the "full-time employment law," officially titled "Draft Law on Full-Time Employment in the Health Sector and for University Personnel and Changes to Certain Laws," was forwarded to parliament by the government on 27 May 2009. However, changes envisaged in the draft law had started to be discussed much earlier.

At its core, the law prevented academics from working in other, non-public institutions. Though the law covered not only members of medical faculties but all academics, opposition and criticism came most strongly and almost only from doctors. This was because the law most affected them, as the practice of part-time, private sector work and self-employment was most embraced by academic members of medical faculties. Academic personnel who worked outside the university were given six months to terminate their non-university, private employment, and in the case of non-termination, they would be considered to have resigned.

The TTB's responses to a possible full-time employment law started as early as 2007 before the law draft was made public. It is significant to note that from then until the end of the process, the TTB stressed in a principle, they do not disagree with full-time employment, but they are concerned about the professional rights of doctors with this re-organization of the employment structure of public hospitals. Gencay Gürsoy then president of the General Council of the TTB, stated that:

> This is part of the HTP related to public hospitals. It is okay if the permanent jobs of doctors will be maintained and the economic conditions of doctors will be improved. But if there is a transition to a contractual-status, it means doctors will become like seasonal workers. Their strike and collective bargaining rights should not be taken away from them.[20]

20 "Tam Gün Çalışalım ama Kadrolu ve Sendikalı," BIANET, September 14, 2007. http://bianet.org/bianet/emek/101783-tam-gun-calisalim-ama-kadrolu-ve-sendikali. (See appendix C.128 for the original.)

While the main criticism of the full-time employment law emphasized the concerns of doctors about job security and professional rights, the draft law was presented as a step towards improving doctor-patient interactions and equalizing access of patients to health care services.

The preamble of the law stated that:

> It is undeniable that the part time employment structure can be defined as a privilege for doctors, permitting them to provide public service and at the same time maintain private professional activities that cannot take away from their public duties. In the services provided outside public health institutions, instead of sharing the work-load of public health institutions, they become intermediaries of access to public health services. It cannot be denied that the part-time working structure, through the decreased efficiency of public institutions, results in diversion of patients consciously or circumstantially to the private sector. The direct money transaction between doctor and patient complicates the access of patients to health services and damages the trust relationship between patients and doctors. It is unacceptable for the professional reputation of doctors.[21]

Notably, in the preamble to the law, the government justified it as a step towards increasing peoples' access to health services by ending "privileges" that had been given to doctors up until then. The arguments in the preamble clearly demonstrate the stance of the government as an actor that protects the rights of health-care service receivers from health-care service providers, as discussed extensively in the 3rd and 4th Chapters on the discursive framework of the government in presenting the HTP.

The law was intensely criticized by doctors through the TTB and SES even before the draft was forwarded to parliament. The law on full time employment was criticized on the grounds that it would deteriorate quality in university hospitals as centers of medical research and reduce them to ordinary public hospitals, as the law did not permit any supplementary payments to

21 "Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun Tasarısı," http://www.basbakanlik.gov.tr/docs/kkgm/kanuntasarilari/tasari26052009.doc. (See appendix C.129 for the original.)

members of the medical faculty from patients. These had formed the core income of revolving funds through which education and research were funded. The dean of the Istanbul Medical Faculty Yanardağ stated:

> Medical faculties are institutions where scientific research and education take place; thus, they have a different quality than state hospitals. As a consequence high-risk patients that cannot be treated in public hospitals opt for university hospitals. With the new law and with decreasing funds, medical faculties will be deprived of research and education possibilities and will become institutions solely occupied with treatment.[22]

Another criticism of the draft law on full time employment focused on its probable effects on the services patients receive in university hospitals as a consequence of the potential resignation of members of the faculty and decreased fundings devoted to research and education. Health rights activist Mustafa Sütlaş expressed his opinion on the issue in the following way:

> If this draft passes into law, some doctors who work in the public sector may choose to resign. This would be a difficulty for patients who have chronic illnesses that require follow up. Doctors will choose places to work according to the salary they will receive, but in any case their income will decrease. Concerns over income will result in lower quality services being delivered to patients.[23]

Hence it is possible to argue that while the law on full-time employment was presented as a step towards equalizing access to health-care services by limiting the "privileges" granted to health-care service providers, critics did not build their arguments solely on the basis of the loss of professional rights and

22 "TTB: Tam Gün Çalışmaya Değil Tam Gün Yasa Tasarısına Karşıyız.," *BirGün,* May 28, 2008. http://www.birgun.net/haber-detay/ttb-tam-gun-calismaya-degil-tam-gun-yasa-taslagina-karsiyiz-40749.html. (See appendix C.130 for the original.)

23 "Tam Gün Yasa Tasarısı Hastaları da Mağdur Eder," BIANET, June 2, 2009. http://bianet.org/bianet/saglik/114938-tam-gun-yasa-tasarisi-hastalari-da-magdur-eder. (See appendix C.131 for the original.)

decrease of income but also as a step toward changing the structure of university hospitals. This structural change would result in the decrease of investments for research and development and the consequence would be the deterioration of the quality of the services.

The law on full-time employment was approved by parliament on 21 January 2010 and published in the *Official Gazette* on 30 January 2010.[24] Following the passing of the law, further criticisms were stated by the TTB underlining their concerns for the future of the Turkish health sector. Osman Öztürk, then member of the executive board of the Istanbul Medical Chamber, criticized Minister of Health Recep Akdağ's justification of the law – that it was a step towards increasing access to doctors – as hypocritical:

> Already a significant proportion of doctors, approximately 85 percent, are working on a full-time basis. For these doctors, this law does not bring about a change. When we look at the 15 percent who work on a part-time basis, there are two types. Literal part-time employment is a practice in medical faculties whereby part-time faculty members work until noon. If they choose to be employed by the university, they will be working full-time after this law. In this respect, what the Minister says is consistent for their case. But when we look at public hospitals, the full-time doctors work there for 9 hours a day while the part-time doctors work for 8 hours.[25]

Recep Akdağ's statement regarding the law was: "Citizens go to the hospital and cannot find a doctor because the doctor is at his private practice. After this law, it will not be like this."[26]

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24 "Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun," http://www.resmigazete.gov.tr/eskiler/2010/01/20100130-1.htm.

25 "Tam gün'den Kalan." *BirGün,* February 2, 2010, http://www.birgun.net/haber-detay/tam-gun-den-kalan-17438.html. (See appendix C.132 for the original.)

26 "Tam gün'den Kalan." *BirGün,* February 2, 2010, http://www.birgun.net/haber-detay/tam-gun-den-kalan-17438.html. "Vatandaş hastaneye gidiyor, doktor bulamıyor. Çünkü doktor muayenehanesinde. Bu Yasa çıktıktan sonra böyle olmayacak."

The full-time employment law was criticized on the grounds that there is a double standard in the law, as members of faculties working in private universities are allowed to work part time while those in public institutions have to choose one work place or the other. Secondly, critics are concerned by the potential decrease in the number of members of medical faculties following the law should they choose to resign and work in their own private practices. This would increase the working hours for the remaining faculty members, which in the end would lead to fewer hours dedicated to research and teaching and eventually decrease the quality of medical education and research.[27]

Certain articles of the law were annulled by the Constitutional Court in July 2010. Following this decision, the TTB justified its objection to this law by underlining inconsistencies in government claims used to introduce this law and by citing the current and potential consequences when considered together with the HTP.

The article of the full-time employment law that made 75 percent of doctors' pay performance-based was among the annulled articles. On this issue, Osman Öztürk stated:

> Three quarters of doctors' income depended on performance in the first version of the law. This is not acceptable in the public sector. In particular, the duty of professors in universities is to conduct research and educate students. This is not remunerated in the law. What was intended was that professors be paid only according to the number of the patients they treated.[28]

Following the partial annulment of the law, criticisms focused on inconsistencies among claims made by the Ministry. Those claims by the ministry aimed to justify the law and its practice in the health system. Eriş Bilaloğlu underlined that this new model would not necessarily decrease extra payments by patients:

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27 Sadık Çelik, "*Tam gün Yasası*," *Cumhuriyet,* January 25, 2010.

28 "Doktorları Muhasebeciye Çevirecek Madde İptal Edildi," *BirGün,* July 20, 2010. http://www.birgun.net/haber-detay/osman-ozturk-doktorlari-muhasebeciye-cevirecek-madde-iptal-edildi-54088.html. (See appendix C.168 for the original.)

> In the newly-established system, much more money is circulated than the extra payments made to doctors. Staff members in university hospitals and teaching-research hospitals are not used effectively. The people are directed to these hospitals for primary and secondary health services; this is a mistaken practice. And there is the declaration of the Minister himself. Hospitals cannot charge more than 30 percent difference, but private hospitals can charge 70 percent difference. In other words, a person with social security coverage who goes to a private hospital to receive treatment is obliged to pay 70 percent difference. The amount of money that circulates within this new system is so huge that the "bıçak parası" that was paid before is insignificant.[29]

One article of the Full-time Employment law rendered complementary payments based on performance; other articles prevented staff members of higher education institutions from working in a private institution or practicing their profession independently. Following the annulment decisions of the Constitutional Court, the Ministry of Health made an official declaration stating:

> According to the decision of the Constitutional Court and the law itself doctors who work in public institutions (except those who are academic members of staff) are prohibited from having their own private practices or working in private health institutions. This will be effective from 30 July 2010.[30]

In response to this interpretation by the Minister of Health, the TTB declared that the Ministry should accept the annulment decision made by the Constitutional Court and should by no means force doctors working in public hospitals to choose between their contracts at public institutions and their other employers or private practices:

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29 "Doktorları Muhasebeciye Çevirecek Madde İptal Edildi," *BirGün,* July 20, 2010, http://www.birgun.net/haber-detay/osman-ozturk-doktorlari-muhasebeciye-cevirecek-madde-iptal-edildi-54088.html. (See appendix C.133 for the original.)

30 "Tam Günde Gerekeni Yaparız," NTV, July 19, 2010, http://www.ntv.com.tr/saglik/ttb-tam-gunde-gerekeni-yapariz,XJxMj5nTtkGrLpr8pji22Q. (See appendix C.169 for the original.)

> The declaration of Recep Akdağ says "It is forbidden for civil servants to have a second job. There used to be a law that permitted doctors working in the state to have a second job. This law provided an exception for doctors. By putting a specific article in the Full-Time Employment Law, we abolished that law that provided this privilege to doctors. The Constitutional Court did not abolish this article that abolished this exception granted to doctors. Under these circumstances, saying doctors cannot both work in public hospitals and have their own consulting rooms does not comply with reality and has no legal validity.[31]

Following this interpretation by the Ministry, the TTB appealed to the Council of State through the CHP to suspend the law's execution for doctors to whom it would be applied, namely those working in public institutions other than higher education institutions.

In addition to this appeal to the Council of State, Eriş Bilaloğlu, then a member of the General Council of the TTB, responded to the Ministry of Health's interpretation of the decision of the Constitutional Court, underlining that the Ministry and the government were portraying doctors as defenders of paid health services:

> We condemn the groundless accusations of the Ministry of Health directed at the TTB that our association is defending paid health services. The TTB has always been a defender of health rights for everyone and for salaries that recompense the work of doctors. The TTB has already submitted a full-time employment law that is grounded on these principles to the Ministry of Health, as well as to public opinion. Minister of Health Recep Akdağ often uses the term "well-to-do doctors" for doctors that have their own practices and also work in the public sector, asking: "Why should an academic member of staff be both department chair and have his own private practice? The reason for this is obvious, the doctor is using his status at the university for

31 "Sağlık Bakanı Dr. Recep Akdağ, Anayasa mahkemesi'nin Kararını Israrla Yanlış Yorumlamaktan Vazgeçmeli ve Sonucu Kabullenmelidir," TTB, July 19, 2010, http://www.ttb.org.tr/index.php/Ek-Haberler/haber-2106.html. (See appendix C.134 for the original.)

> his private consultations." We would like to ask Recep Akdağ whether he worked in that manner when he was a member of the academic staff at Atatürk University's Medical Faculty?[32]

The Council of State granted the motion for a stay of execution following the appeal of the CHP. The Ministry of Health objected to this decision, but the Council of State maintained their decision for a stay of execution. Following this development, Minister of Health Recep Akdağ made a declaration on the decision of the Council of State:

> Do you know what the whole matter is about? Those who have some privileges, those who consider themselves superior to us, are uncomfortable. According to them, we cannot govern this country. According to them the elite, the privileged should do this. According to them the son of a craftsman from Kayseri cannot be president, but he certainly did, eventually.[33]

This statement by Akdağ is in line with the broader approach of the government and the Ministry of Health of portraying doctors as elites who object to the health reforms proposed by the government in order to protect their privileges. This approach is in line with the general discourse of the government of a new Turkey defined as a place where people previously victimized by the elites of the country now receive just, equal treatment from the state. Health, as discussed in earlier chapters of this dissertation, emerges as an area where this discourse can be clearly observed.

The TTB opposed being portrayed by the Ministry of Health and the government as not supporting unpaid health services for the people. This is an example of how doctors are portrayed as elites who oppose the health policies

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32 "Sağlık Bakanı Dr. Recep Akdağ, Anayasa mahkemesi'nin Kararını Israrla Yanlış Yorumlamaktan Vazgeçmeli ve Sonucu Kabullenmelidir," TTB, July 19, 2010, http://www.ttb.org.tr/index.php/Ek-Haberler/haber-2106.html. (See appendix C.135 for the original.)

33 "Akdağ: Kararı Uygulayacağız ama Muayene Çilesine Müsade Etmeyeceğiz," Medimagazin, August 27, 2010 http://www.medimagazin.com.tr/ana-sayfa/tam-gun-yasasi/tr-akdag-karari-uygulayacagiz-ama-muayene-cilesine-musaade-etmeyecegiz-1-77-28664.html. (See appendix C.136 for the original.)

of the AKP in order to protect privileges that are obstacles to the people's access to health services. Recep Akdağ stated "The TTB will account for what they have done before history,"[34] to which the TTB responded in a lengthy declaration that the Ministry of Health needs to account before history for privatizing health services and increasing the copayments of the people.[35]

The Full Time Employment Law was last modified in 2014, and professors and associate professors were allowed to have a second job in private hospitals and private universities on the condition that the number of associate professors and professors working in private institutions not constitute more than the 50 percent of those in their departments.[36]

8.2.2 *Violence towards Doctors*

The violence faced by health care practitioners is on the agenda of both the Ministry of Health and its opponents led by the TTB. These two actors who are on opposing sides regarding health policies are unsurprisingly concerned about this issue. However, the approach of the TTB and other organizations acting in tandem with them is based on an argument that the HTP and changes taking place in the health sector are an important factor in the increase of violence towards health-care providers and specifically doctors.

Violence against doctors, especially by patients' relatives, has always been an issue but the murder of Göksel Kalaycı in the parking lot of the hospital at which he worked on 11th November 2005 made violence against doctors a subject of discussion among the main actors in the health sector scene, namely the TTB and the unions. Investigations revealed that Kalaycı was attacked one week before his murder in the elevator of his private clinic. The attacker was

34 "Mutsuz Hekim Sağlık Sunamaz," *Evrensel,* July 30, 2010, https://www.evrensel.net/haber/184333/mutsuz-hekim-saglik-sunamaz.

35 "Sağlık Bakanı Dr. Recep Akdağ, Anayasa mahkemesi'nin Kararını Israrla Yanlış Yorumlamaktan Vazgeçmeli ve Sonucu Kabullenmelidir," TTB, July 19, 2010, http://www.ttb.org.tr/index.php/Ek-Haberler/haber-2106.html.

36 "Tam Gün Yasası'nın Uygulaması ile ilgili Genelge," April 16, 2014, https://dosyamerkez.saglik.gov.tr/Eklenti/4242,2014-15-tam-gun-yasasi-uygulamasipdf.pdf?0.

the relative of a cancer patient of Kalaycı who passed away a few hours before the murder.[37]

The initial reactions and comments on the murder came from the Istanbul Medical Chamber, and a march called "Invitation to Think" (Düşünmeye Davet) was organized with doctors carrying banners saying: "We do not want to be targets," "Say no to violence against doctors," "Doctors are not responsible for the problems in health." Apart from making a call for individual disarmament and voicing concern about the increasing violence in society, Gencay Gürsoy, President of the TTB General Council at the time, underlined that doctors are made the scapegoat for problems in the health system:

> Unfortunately this is neither the first nor the last case. Doctors who have been shown as the target of problems in health and have eventually become the targets of violence. The atmosphere in which doctors work in emergency services is a life and death situation.[38]

The chair of the "Üniversite Öğretim Üyeleri Derneği" (Association of Academics) Tahsin Yeşildere stated that: "By disregarding the corruption in the health system, doctors are pointed to as targets, and this is not correct. This influences uneducated people in society in the wrong way, so such statements should be avoided."[39]

The chair of the Ankara Medical Chamber Semih Tatlıcan stated that:

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37 "Profesör Cinayeti Böyle Çözüldü," *Vatan,* November 17, 2005. http://www.gazetevatan.com/profesor-cinayeti-boyle-cozuldu-64580-yasam/ "Prof. Dr. Göksel Kalaycı Öldürüldü," BIANET, November 11, 2005, http://bianet.org/bianet/insan-haklari/70137-prof-dr-goksel-kalayci-olduruldu.

38 "Doktorlar: Hedef Tahtası Olmak İstemiyoruz," BIANET, November 15, 2005, http://bianet.org/bianet/emek/70210-doktorlar-hedef-tahtasi-olmak-istemiyoruz. (See appendix C.170 for the original.)

39 "Sağlık sisteminin çarpıklığı ve yozlaşmasının göz ardı edilerek hekimlerin hedef gösterilmesinin çok yanlış olduğunu, bunun toplumdaki eğitimsiz kişileri olumsuz etkilediğini vurgulayan Prof. Dr.Yeşildere, bu tür açıklamalardan kaçınılmasını istedi." "Doktorlar: Hedef Tahtası Olmak İstemiyoruz," BIANET, November 15, 2005, http://bianet.org/bianet/emek/70210-doktorlar-hedef-tahtasi-olmak-istemiyoruz.

> Doctors should not join such demonstrations regarding violence. Where are we going? The attacks made on both doctors and other health personnel are terrifying, and this is not only a current problem; all the negativities regarding the health sector paved the way for such a tragic event.[40]

These initial reactions by the TTB and medical chambers clearly demonstrate that violence against doctors was considered in light of doctors being accused of the failings of the health sector. Even though not directly stated in the abovementioned statements, the HTP is regarded as a key factor in the increase in violence as demonstrated in the results of a report published by the TTB.

According to research conducted by the TTB based on data gathered by various medical chambers in Turkey, there have been 37 attacks reported directed at doctors in hospitals since 2002 (including the murder of Göksel Kalaycı). The TTB Secretary General of Orhan Odabaşı explained that some attacks are not mentioned in the report:

> Some doctors do not feel at ease reporting attacks they experience as they feel abased by the act. We have doctors who are shouted at, threatened, beaten, and shot by patients' relatives. But most doctors do not feel comfortable reporting these and then feel distanced from their profession.[41]

The presentation of the report by the TTB stated that: "Doctors are held responsible for problems stemming from changes taking place especially as a

40 "Sağlık Sisteminin Faturası Yine Hekimlere Kesiliyor," *BirGün,* November 16, 2005. http://www.birgun.net/haber-detay/saglik-sisteminin-faturasi-yine-hekimlere-kesiliyor-yuzlerce-24970.html." (See appendix C.137 for the original.)

41 "Doktora Şiddet Artıyor," *BirGün,* December 4, 2005. http://www.birgun.net/haber-detay/doktora-siddet-artiyor-25192.html. (See appendix C.138 for the original.)

consequence of the HTP, and this diverts the reactions of patients' relatives to doctors when they find no other person responsible around them."[42]

Following the murder of Göksel Kalaycı and increasing cases of violence against doctors, the TTB established a "Zero Tolerance of Violence Working Group" and a website gathering studies on this issue.[43] Following the murder of Göksel Kalaycı, a number of studies were conducted by different medical chambers such as "Report on Violence towards Doctors and Health Personnel" by the Ankara Medical Chamber, "Violence Report in Health Sector I" by the Gaziantep-Kilis Medical Chamber, and "Violence and Perception of Violence towards Health Employees in Isparta and Burdur" by the Isparta-Burdur Medical Chamber. These reports were shared and discussed during a workshop organized by the Istanbul Medical Chamber on 14 February 2009.[44] According to research conducted in various provinces by medical chambers, public health institutions are more prone to violence towards doctors, and these events are experienced most frequently in emergency clinics. General practitioners are more exposed to violence than specialized doctors, and women are more vulnerable to violence than their male colleagues.[45]

A presentation made during the workshop "Hekime Yönelik Şiddet Nasıl Önlenir? Çalıştay" (How to Prevent Violence to Doctors? Workshop) by Ali Özyurt shows how doctors and the TTB approach and interpret the violence towards doctors. The TTB conducted research by sending a questionnaire to members in order to understand the approach and perception of violence towards doctors and health personnel. When asked to list the reasons behind the violence, doctors most list HTP as the cause. They state that a free market economy is an important factor that leads to violence. Another factor that is

42 "TTB, özellikle sağlıkta dönüşüm programının uygulanması yla sağlık sisteminde meydana gelen aksaklıkların doktorlara fatura edildiğini, sağlık sistemini beğenmeyen hasta yakınlarının, ortada sorumlu bulamayınca tepkilerini doktorlara yönettiğini düşünüyor." "Tıpta Utanç Rekoru: 5 Dakikada Tedavi," *BirGün,* November 19, 2005. http://www.birgun.net/haber-detay/tipta-utanc-rekoru-5-dakikada-tedavi-25004.html.

43 "Türk Tabipleri Birliği Şiddet Çalışma Grubu," TTB, https://www.ttb.org.tr/siddet/

44 "Hekime Yönelik Şiddet Nasıl Önlenir? Çalıştay" İstanbul Tabip Odası, May 2009, http://www.ttb.org.tr/siddet/images/file/itocalistay.pdf.

45 "Hekimlere Yönelik Şiddet: 1 Ölü 48 Yaralı," BIANET, December 17, 2010. http://bianet.org/bianet/siyaset/126664-hekimlere-yonelik-siddet-1-olu-48-yarali.

stated to lead to violence is the lack of workflow diagrams. Doctors who work in emergency services report more complaints. As they are also responsible for registering patients, they state that they cannot deal with patients sufficiently in emergency units. As a consequence, they face problems. According to Özyurt, another frequently mentioned factor by doctors who answered the questionnaire was a loss of professional prestige after the 12 September coup d'état and especially under AKP governments when the health sector and its liberalization became a political tool. As a consequence, it is stated that doctors and health personnel are presented as the reasons behind problems in the health sector, and this created a mistaken perception among patients' relatives.[46]

Violence against doctors and health personnel continues to be on the agenda of the TTB and other health sector unions. Some major cases such as the murder of Ersin Arslan in Gaziantep by a patients' relative on 18 April 2012[47] and the suicide of Melike Erdem on 30th November 2012[48] as a consequence of an investigation following a patient's complaint, triggered an intense discussion over the issue of violence in the health sector. As demonstrated in the above mentioned statements of the TTB and health sector unions, the major argument is that the marketization and increasing workload of doctors paired with the government's presentation of doctors as responsible for problems in the health sector has led to a loss of doctors' reputation and prompted violence against them. This argument is in line with the analysis made in the previous chapter in which health care providers and health-care receivers are presented as opposed and in which the government positioned itself on the side of receivers, bringing an end to the victimization caused by health care service providers.

46 "Hekime Yönelik Şiddet Nasıl Önlenir? Çalıştay" İstanbul Tabip Odası, May 2009, http://www.ttb.org.tr/siddet/images/file/itocalistay.pdf, 30-35.

47 "AKP Gidici Mücadele Kalıcı," SendikaOrg, April 24, 2012, http://sendika63.org/2012/04/cerkezoglu-akp-gidici-mucadele-kalici-burak-oz-birgun-66067/.

48 "Doktorların Ölümle Dansı ve Sabim Jurnal Hattı," *BirGün,* December 7, 2012. http://www.birgun.net/haber-detay/doktorlarin-olumle-dansi-ve-sabim-jurnal-hatti-63430.html.

8.2.3 *Compulsory Service*

Compulsory service for doctors was introduced by Law No. 2514 entitled "Law on Public Service Liability of Certain Health Personnel" on 25.08.1981. This law was modified in 1986, 1989, and 1995 when the duration of compulsory service was changed. From 1985 onwards, graduates of medical faculties were granted the right to take a medical specialization exam before fulfilling their compulsory service. This law was in practice until 24 July 2003. At that time, Law Number 4924 was passed entitled "Law on Modifications to be Made to Some Statuary Decrees and Laws on the Employment of Health Personnel in Places where Recruiting is Difficult."[49] With this law, the government aimed to encourage health personnel to voluntarily seek contractual employment in eastern provinces by providing 7 to 2.5 percent higher payments.

As discussed in Chapter 5, this law was introduced by the government to end the victimization of citizens in eastern provinces who are deprived of health services because health care providers do not choose to work there. The claim of the Ministry was that in order to decrease disparity among regions and abolish victimization caused by a lack of health personnel, they made employment in the eastern provinces an "attractive" option through increased salaries rather than obligation.

However, the view of the government on the subject changed, and a modified compulsory employment was reintroduced in Law Number 5371 on 21. 06. 2005.[50] The Ministry of Health declared that during the 2 year period from 24.07.2002 until 21.06.2005, 1081 vacant contractual-employment positions for specialist doctors were announced. 200 specialist doctors were placed in those vacancies and 136 started work. During the same period, 3524 vacancies for

49 "Eleman Temininde Güçlük Çekilen Yerlerde Sözleşmeli Sağlık Personeli Çalıştırılması ile Bazı Kanun ve Kanun Hükmünde Kararnamelerde Değişiklik Yapılması Hakkında Kanun," http://www.resmigazete.gov.tr/eskiler/2003/07/20030724.htm.

50 "Sağlık Hizmetleri Temel Kanunu, Sağlık Personelinin Tazminat ve Çalışma Esaslarına Dair Kanun, Devlet Memurları Kanunu ve Tababet ve Şuabatı San'atlarının Tarzı İcrasına Dair Kanun ile Sağlık Bakanlığının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararnamede Değişiklik Yapılmasına Dair Kanun," June 21, 2005 http://www.resmigazete.gov.tr/eskiler/2005/07/20050705-2.htm.

general practitioners were announced. 2191 general practitioners were placed and 1565 started work. By comparison, in the year 2002 during which compulsory employment for doctors was still in practice, 1425 specialist doctors and 735 general practitioners were recruited within the framework of the Public Officers Law (Devlet Memurları Kanunu). Over the previous two year period, these numbers were 1425 and 2735, respectively.[51]

Based on the above-mentioned justification, Cevdet Erdöl presented a draft law that reintroduced compulsory employment for health personnel in June 2005. The law passed in parliament on 21 June 2005, upon which doctors were obliged to perform compulsory service as part of their six-year medical training and any other specialist training they receive. The durations of compulsory service are determined by the law and depend on to which provinces they are appointed. The classification of the regions are made according to socio-economic level as determined by the State Planning Organization.[52]

The reintroduction of compulsory service was contested by the TTB and other unions such as SES. Compulsory service was mainly objected to as it withholds the freedom to practice their profession from new graduates. Another major argument is the insufficient infrastructure in the regions to which doctors are planned to be appointed. At different stages of the passing of this law –from the introduction of the draft until its enactment - and during legal proceedings when the TTB appealed to the Council of State, the contesting actors publicly presented their arguments objecting to the introduction of compulsory service. They not only underlined the disadvantages of compulsory service for themselves but also for health care receivers.

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51 "Trabzon Milletvekili Cevdet Erdöl ile 2 Milletvekilinin; Sağlık Hizmetleri Temel Kanunu, Sağlık Personelinin Tazminat ve Çalışma Esaslarına Dair Kanun, Devlet Memurları Kanunu ve Tababet ve Şuabatı San'atlarının Tarzı İcrasına Dair Kanun ile Sağlık Bakanlığının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararnamede Değişiklik Yapılmasına Dair Kanun Teklifi ile Sağlık, Aile,Çalışma ve Sosyal İşler Komisyonu Raporu (2/506)," https://www.tbmm.gov.tr/sirasayi/donem22/yil01/ss934m.htm

52 "Sağlık Hizmetleri Temel Kanunu, Sağlık Personelinin Tazminat ve Çalışma Esaslarına Dair Kanun,Devlet Memurları Kanunu ve Tababet ve Şuabatı San'atlarının Tarzı İcrasına Dair Kanun ile Sağlık Bakanlığının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararnamede Değişiklik Yapılmasına Dair Kanun," http://www.resmigazete.gov.tr/eskiler/2005/07/20050705-2.htm.

For instance, following the initiation of discussions on compulsory service in parliament, Ali Çerkezoğlu, then Secretary General of the Istanbul Medical Chamber, emphasized that compulsory service would not necessarily solve the disparity among regions or provide better health service to citizens living in those areas. On this issue he stated:

> A government that sincerely wants to resolve the health problems of the less-developed regions of Turkey should accept health as a right acquired by birth for all citizens, make the necessary investments to abolish the deeply-rooted crisis of the public health system, and rapidly improve the personal benefits of both doctors and health personnel.[53]

Çerkezoğlu also contested claims made by the Minister of Health that stressed the unwillingness of doctors to go to less-developed regions despite improved salaries:

> The claims made by the Minister such as "we provided 9-10 billion in salaries to doctors but still could not convince them to go to Southeastern Turkey." are not true. The government put a contractual employment model into place and tried to recruit doctors with no job security after it abolished compulsory service two years ago. Doctors did not accept their job security being taken from them. Additionally, the amount of the salaries claimed to have been paid do not at all reflect the reality.[54]

Following the passing of the law, a legal process started in order to have compulsory employment annulled. The TTB filed a case with the Council of State for the annulment of the law and to request a stay of execution on 12 September 2005.

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53 "Hekimler Mecburi Değil Gönüllü Hizmet İstiyor," BIANET, June 17, 2005, http://bianet.org/bianet/toplum/62526-hekimler-mecburi-degil-gonullu-hizmet-istiyor. (See appendix C.140 for the original.)

54 "Hekimler Mecburi Değil Gönüllü Hizmet İstiyor," BIANET, June 17, 2005, http://bianet.org/bianet/toplum/62526-hekimler-mecburi-degil-gonullu-hizmet-istiyor. (See appendix C.141 for the original.)

The TTB justified the filing of the case with the Council of State in the following way:

> Compulsory service does not comply with Article_5 of the Constitution which states that the state should provide necessary conditions for the material and moral development of the people and should abolish social, economic and political obstacles that limit the fundamental rights and liberties of the individual in a way that does not comply with social law state and principles of justice. It is against Article_10 of the Constitution that regulates the principle of equality. It is against the principle "Permanency and supremacy of the constitution" that is foreseen by the article_11 of the Constitution. It is against the principle of limitation that is indicated by the Article_13 of the Constitution. It is against the Article_18 of the Constitution that indicates a "ban on forced labor." It is against the "freedom of science and art" mentioned in the Article_27 of the Constitution. It is against the "right and responsibility of education and training" that is foreseen in the Article_42 of the Constitution.[55]

The Council of State Department number 5 granted a motion for a stay of execution of the circular on compulsory service[56] and appealed to the Constitutional Court for the annulment of certain articles of the law entitled "Basic Law on the Health Services"-which was modified by Law No. 5371- and formed the basis of the circular. The application of the Council of State was

55 "Doktordan Mecburi Hizmet Davası," *BirGün,* August 2, 2005, http://www.birgun.net/haber-detay/doktordan-mecburi-hizmet-davasi-23834.html. (See appendix C.142 for the original.)

56 "2005/22 sayılı "Devlet Hizmeti Yükümlülüğü" konulu Başbakanlık genelgesinin iptali için TTB tarafından Danıştay'a verilmiş Dava Dilekçesinin Tam Metni," TTB, December 20, 2010, http://www.ttb.org.tr/data/haber/subat06/danistay_karar.php. "Danıştay Zorunlu Hizmete İlişkin Anayasa Mahkemesi'ne Başvurma Kararı Verdi ve Uygulama Genelgesinin Yürütmesini Durdurdu," TTB, February 2, 2005, http://www.ttb.org.tr/data/haber/subat06/mecburi.php.

finalized by the Constitutional Court on March 2006 and the detailed ruling was published in the *Official Gazette* dated 11 December 2007.[57]

The Constitutional Court did not annul all the articles presented by the Council of State. The detailed ruling stated that exemption from compulsory service for those who studied in medical faculties abroad at their own expense was against the constitution. Thus, anyone who would like to practice their profession as a doctor in Turkey, regardless of whether they studied abroad at their own expense, would have to complete the compulsory service. The Constitutional Court rejected the request to annul the article that required doctors to complete compulsory service as general practitioners and for each specialization or subspecialization education they received. Those that completed their education before the Council of State adopted the motion for a stay of execution had to complete compulsory service both as general practitioners and also as specialists. However, the Constitutional Court annulled the article that obliged doctors who were already graduates of medical faculties and who had already started their specialization education to complete the compulsory service as a general practitioner.[58]

Following the decision of the Constitutional Court, Gencay Gürsoy, then Chair of the Istanbul Medical Chamber, evaluated the development and criticized the reintroduction of compulsory service. He focused both on how doctors did not oppose serving in the regions included in the compulsory service scheme but they opposed the conditions under which they would work. He also focused on the aspect of inequality of the compulsory service introduced for doctors:

> Our young colleagues will practice their profession as an obligation from now on. We are not convinced that this is an appropriate formula.

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57 "Devlet Hizmeti Yükümlülüğüne ilişkin 5371 Sayılı Yasa hakkındaki Anayasa Mahkemesi Gerekçeli Kararı," TTB, December 11, 2007, http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=612:devlet-hmetyle-k-5371-sayili-yasa-hakkinda-kanayasa-mahkemesgereklkarari&catid=24:belgeler&Itemid=41.

58 "Zorunlu Hizmete İlişkin Anayasa Mahkemesi Kararı," https://www.ttb.org.tr/en/index.php/tuem-haberler-blog/107-mecburi-hizmet/98-qzorunlu-hmeteq-ili-anayasa-mahkemesi-karar "Reasoned Decision of the Constitional Court" Resmi Gazete (Official Gazette) December 11, 2007 http://www.resmigazete.gov.tr/eskiler/2007/12/20071211-6.htm.

> This service should have been made an obligation but voluntary. If the necessary precautions were taken, doctors would willingly go to places of deprivation. Judges, prosecutors, and teachers go to those places, so why wouldn't doctors? I would like to underline the injustice here, because when a doctor does not go the state imposes an embargo on his diploma. But when a judge decides not to go to where he is appointed, he can resign and work as a lawyer. When a teacher does not go to the appointed work place, he can work in the private sector. We support the willingness and excitement to provide doctors to eastern regions, but it should not be done in this manner, because it is worse to have a doctor practice his profession by force than not to have a doctor.[59]

8.2.4 *Family Practitioner Model*

The family practitioner model was initially announced in the election program of the AKP before the 2002 Parliamentary Elections. Then it was included in the Emergency Action Plan of the first AKP government among health sector goals to be realized in its first year. Law No. 5258 entitled "The Law on the Family Practitioner Pilot Scheme" was published in the *Official Gazette* number 25650 on 24.11.2004. The regulation on the "Family Practitioner Pilot Scheme" was published in the Official Gazette on 06.07.2005, and on 15.09.2005 a pilot scheme started in Düzce province. By the end of 2010, following the publication of a regulation on family practitioner practice, the family practitioner model started to be practiced in all provinces of Turkey.[60]

As discussed in detail in Chapter 4, the family practitioner model was presented by the AKP and especially by the Ministry of Health as a necessary, efficient, world-standard way of delivering primary health care services to people.

This model is criticized by health care provider groups on two grounds, however. Firstly, it is criticized as the family practitioner model results in the

59 "Mecburi Hizmete Devam," Medimagazin, March 20, 2006, http://www.medimagazin.com.tr/medimagazin/tr-mecburi-hizmete-devam-676-272-2557.html. (See appendix C.143 for the original.)

60 "Türkiye'de Aile Hekimliği," Halk Sağlığı Genel Müdürlüğü, December 1, 2017, http://ailehekimligi.gov.tr/aile-hekimlii/tuerkiyedeki-aile-hekimlii.html.

closure of "sağlık ocakları" where people receive primary health care services free of charge. Secondly, the Family Practitioner Model was criticized because in some provinces the application of doctors for these positions are forced when there are not enough applicants, even though it was not a compulsory service. Another major criticism focused on the working conditions of doctors in the family practitioner system.

Before the pilot scheme for the family practitioner model was initiated in Düzce province, a call for applications was made for 99 family practitioner positions. When the number of applicants remained below this number, doctors in Düzce province claimed that the Ministry of Health threatened to appoint them to other provinces if they did not agree to work as family practitioners. The person responsible for the General Practitioner division of the TTB, Kurtuluş Arıkök, stated:

> The statement sent to doctors by the governorship of Düzce demanded that doctors decide whether they will agree to work as a family physicians in one day. The practice that forces doctors to make a decision in one day should be annulled. They do not have health personnel volunteers for family physician practices, so doctors who do not apply are threatened with appointment to out-of-province positions. Doctors will not implement any decision without discussing and questioning in an unorganized manner. We urgently invite the Ministry of Health to end this oppression and not attempt to change the workplaces of our colleagues who do not agree to work as a family physicians.[61]

Köksal Aydın, then chair of the union SES, emphasized his concerns regarding the appointment of family physicians: "We understood that doctors and health personnel who signed contracts to work in family physician centers did not do so voluntarily. These doctors think that their job security is in danger."[62]

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61 "TTB: Aile Hekimliği Dayatması Geri Çekilsin" BIANET, August 24, 2005, http://bianet.org/bianet/saglik/65730-ttb-aile-hekimligi-dayatmasi-geri-cekilsin. (See appendix C.144 for the original.)

62 "Aile hekimliğinde sözleşme imzalayan hekimlerle çalışanların, bu konuda gönüllü olmadıklarını anladık. Hekimler, iş güvencelerinin tehlikeye girdiğini düşünüyor." "Aile Hekimliği

Concerns over the working conditions of doctors in the family physician model started as early as 2003. Feride Saçaklıoğlu, who was at the time chair of the Public Health Department at Ege University's Medical Faculty, stated that:

> Doctors who work as family physicians will be employed in a contractual manner and be deprived of their job security and social rights. In community clinics (*sağlık ocakları*), a team works all together, but when the doctor is forced to earn his living through "bargaining," the team spirit will disappear and morale will erode.[63]

Doctors forced to work as family physicians became an issue on the agendas of doctors in various provinces. A case in Denizli in 2006 is one of them. Mehmet Neşşar, at the time an mp of the CHP, claimed that because 62 percent of doctors in Denizli did not agree to work as family physicians, the work places of around one hundred doctors were being changed as a punishment. Neşşar underlined that as a result, experienced doctors working in outpatient clinics specialized in tuberculosis, thalassemia, and diabetes were displaced, and those dispensaries were unable to function.

On this issue the Denizli Medical Chamber stated:

> The appointments and secondments made among doctors who did not agree to work as family physicians violated the related law, regulation, and "Directive on the Practices of Placing Family Physicians in Denizli Province." Upon a decision made solely by governor Dr. Hasan Canpolat, the appointments and secondments were made contrary to the aforementioned regulation. Additionally, as a consequence, some crucial centers such as Tuberculosis Dispensary, the Thalassemia Center of the Denizli Province Health Department, [and] the Diabetes Center

Sağlığı Piyasalaştırıyor," BirGün, September 22, 2005, http://www.birgun.net/haber-detay/aile-hekimligi-sagligi-piyasalastiriyor-24384.html.

63 "İş Güvencesi Yok," *Cumhuriyet*, November 25, 2003. (See Appendix C.192 for the original.)

> of the Denizli Province Health Department have been rendered dysfunctional.[64]

This case in Denizli demonstrates that the family physician model presented by the government and the Ministry of Health as a new health-care provision model that would more efficiently meet the needs of the people did not receive the necessary number of applicants in all provinces.

Apart from underlining the reasons for the insufficient number of applicants for vacant family physcian positions, such as concerns over contractual employment, medical chambers criticized the consequences faced by doctors who did not apply – forced appointments to out-of-province vacancies. Some medical chambers pressed charges against provincial health directorates to cancel the forced appointments.[65]

The hesitancy of doctors to apply for work as family physicians was caused by uncertainties about how the family practice centers would be regulated in the future and the employment status of the doctors who would work there. Right before placements for family practice centers were made, the Chair of the Mersin branch of SES Yılmaz Bozkurt stated that:

> The family physician model is trying to be made widespread by promising three times more salary than doctors who work in the community clinics (sağlık ocakları). When the family physician model is practiced all over the country, the amount of the salaries will decrease. Family physicians will be forced to make annual and individual contracts with the SGK to work. They will not be able to return to their previous positions. With the closure of the community clinics, there

64 "Denizli'de Aile Hekimliği Skandalı Büyüyor," *BirGün,* December 17, 2006. http://www.birgun.net/haber-detay/denizli-de-aile-hekimligi-skandali-buyuyor-30516.html. (See appendix C.146 for the original.)

65 "Denizli'de Aile Hekimliği Başlamadan İflas Etti," SendikaOrg, December 17, 2006. http://sendika12.org/2006/11/denizlide-aile-hekimligi-baslamadan-iflas-etti/.

> will be no workplace to be returned to for those doctors. In this process, family physicians will be transformed into paid employees of private hospitals.[66]

The family physician practice started in Istanbul on 1 November 2010. Before this, the Istanbul Medical Chamber made a press announcement voicing concern about the consequences of this practice for both health care service providers and receivers. Their statement underlined that the family practitioner system, apart from the working conditions of doctors, had consequences due to disparities among various parts of the city:

> 345 out of 3645 family practice centers are without any employees. These centers are located in districts which are densely populated by poor people, such as Bağcılar, Esenler, and Sultangazi. The family practitioner model is making the already-present inequalities in health even more profound from the beginning.[67]

The working conditions of family physicians stemming from the model as designed is emphasized in the same statement:

> These doctors working as family practitioners have to rent their own buildings, attire 'customer/patient' from their family practitioner colleagues that work in the same zone, cover their own expense, hire employees on their own behalf, pay tax and insurance premiums themselves, and worst of all, they work with annual contracts.[68]

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66 "Aile Hekimliği Toplum Sağlığına, Hekimler Uygulamaya Karşı," BIANET, May 28, 2010, http://bianet.org/bianet/toplum/122327-aile-hekimligi-toplum-sagligina-hekimler-uygulamaya-karsi. (See appendix C.147 for the original.)

67 "Aile Hekimliği İstanbul'da Ciddi Sorunlarla Başlıyor," BIANET, October 22, 2010, http://bianet.org/bianet/siyaset/125620-aile-hekimligi-istanbul-da-ciddi-sorunlarla-basliyor. (See appendix C.148 for the original.)

68 "Aile Hekimliği İstanbul'da Ciddi Sorunlarla Başlıyor," BIANET, 22 October 2010, http://bianet.org/bianet/siyaset/125620-aile-hekimligi-istanbul-da-ciddi-sorunlarla-basliyor. (See appendix C.149 for the original.)

The Istanbul Medical Chamber also emphasized in their statement that the start of the family physician model in Istanbul would have direct consequences for emergency services in state hospitals:

> Doctors working in 112 emergency services will decrease from 372 to 170, and this will cause a serious disruption of emergency health care services. General practitioners, whose number is already less than sufficient, have chosen to work as family practitioners or were obliged to do so, and as a consequence, the emergency services of state hospitals have been emptied out.[69]

Contrary to the portrayal in government discourses as a novelty that ensures improved health service provision, the family practitioner model is criticized and contested by medical chambers as a system that forces doctors to work with short-term contracts. It is argued that the family practitioner model also transforms doctors into entrepreneur-shop-owner merchants responsible for the infrastructure of the family practice centers, and the only way of sustaining these centers is by ensuring that they have a certain number of patient-clients. This argument of the medical chambers is in line with their broader discourse emphasizing that the HTP makes health more commodified in the long term, that it will be harder for people to reach, and that it will take away the job security of doctors and health personnel.

§ 8.3 Concluding Remarks

This chapter which concluded the Part 3 of the dissertation regarding the contesters of the health reform was on the consequences of the health reform in Turkey for the health care practitioners and health care service receivers. Chapter 7 that discussed the concerns of the TTB regarding the commodifying impact of the health reform while this current chapter focused on discuss-

69 "Aile Hekimliği İstanbul'da Ciddi Sorunlarla Başlıyor," BIANET, October 22, 2010, http://bianet.org/bianet/siyaset/125620-aile-hekimligi-istanbul-da-ciddi-sorunlarla-basliyor. (See appendix C.150 for the original.)

ing the outcomes of this commodification impact on both health care receivers and providers. The outcomes foregrounded by the TTB in this chapter were the epidemics, infant mortality, the full-time employment law, violence towards the doctors and the concerns regarding the family physician model.

As discussed earlier concern for public health is a characteristics of the TTB that differentiates it from a classically defined professional association. The cases of cholera and bird-flu were foregrounded by TTB to underscore the consequences of the decisions by the government in decreasing the investments to the primary care. The episodes of bird-flu and cholera emerged in the discourses of TTB as manifestations of their concern for the deterioration of public health and threat to the health right of people as a consequence of the closure of community clinics which were crucial in preventing the epidemics especially in small towns and villages where the access to secondary and tertiary health units are limited. The increase in the working hours of the doctors as well as decreasing investments regarding the primary health care were underscored by the TTB as reasons behind the fast spread of the aforementioned episodes of epidemics.

The criticisms regarding the full time employment law and the family physician model emerged in the discourses of the TTB not only as cases that would concern the professional rights and working conditions of doctors but also as threats to the health rights of the people. TTB highlighted that the full-time employment law in principle is an ideal arrangement to the health sector as long as personal benefits and professional rights of the doctors are guaranteed. They emphasize that with the proposed change not only the personal benefits of the doctors would deteriorate but also as the new law would limit the revolving fund –which is the main source of purchasing equipment and funding for research in the medical faculties- the long-term and consequence of this change would in the long-run have devastating impacts in the medical education and tertiary and secondary health-units. As for the family physician model besides their concern over the organization of the family physician centers as almost privately-run clinics and the enforcement of the doctors to practice their professions as family physicians outside their own will, TTB argues that this new model of primary care replacing the free-of-charge community clinics would have devastating consequences for the public health.

Finally the increased violence towards doctors was underscored by the TTB as a direct consequence of the portrayal of the doctors as the sole responsibles of the malfunctionings of the health system by the government. Additionally TTB argued that the decline in the quality of the health services as a consequence of the commodifying impact of the health reform increased the frustration of the health-care receivers who directed this frustration directly to the health care providers. To conclude, despite the division of the chapter into two parts to analyze the impacts of the health reform according to the TTB as mentioned above the cases presented in this chapter highlight how intertwined these concerns are in terms of the groups – receivers and providers - they impact. This chapter in this sense is a sum of the consequences of the health care reform in Turkey perceived and portrayed by the TTB. These perceptions and portrayals converge on how both discursive framing and the actual actions by the government in both short and long term result in the fundamental change in the health sector in Turkey where the two sides of the sector are divided as opposing sides and health is becoming less a right than a commodity.

9

Conclusion

In the academic literature and in texts written outside academia, the ethos of the AKP is not described without mentioning frequently-appearing themes of "eliminating victimization" and "consolidating justice." Since its early days, the AKP has defined itself as an actor that aims to establish justice for the "people" who-it claimed- had until then been ignored and victimized by the country's elite. The self-narrative of Recep Tayyip Erdoğan regarding his own imprisonment due to a poem he read in 1997, the regulations that restricted religious (*imam hatip*) high school graduates exclusively to undergraduate programs related to theology and the ban on veils in public offices and universities were repeatedly emphasized by the AKP as examples of "the people's victimization" in Turkey, which it promised to end.

Along with these themes of "victimization" that the AKP attributed to the secular policies of the Turkish Republic, the AKP's arguments foregrounded the theme of people being deprived of services in the decades preceding the AKP's rule. The AKP frequently emphasized that it aims to establish justice and that the period in which elites dominated society came to an end when it came to power. This new period was called a "New Turkey" where -the AKP claimed- the government's role changed from being "a ruler elite" to a "servant of the people." Health became an area, together with transportation, that AKP governments used to manifest their commitment to building a "New

Turkey" - dominant themes frequently invoked in both the AKP's electoral campaigns and its broader political discourse.

The main research question of the dissertation was: How and why the health reform debate became a key site of construction of AKP's populist politics that rests on construction of a "New Turkey" - where the inequalities created by the elites are claimed to be abolished- despite the commodifying and inegalitarian outcomes of the health reform? The sub research questions asked for tracing the main question were: How did the AKP discourse present and justify reform in health care? How is the narrative of the AKP's success reflected in electoral campaigns through health? In what ways did the broader populist politics and discourse of the AKP materialize in its specific discourse on health care reform? How were the main themes of populist politics (such as anti-elitism and serving the people) reflected in the AKP's discourse on health care reform? How was the opposition movement shaped? What were the main arguments of the opposing actors? How did the oppositional discourse stand and to what extent was it effective vis-à-vis the AKP's pro-reform discourse?

In order to explore these questions, the study took the "thin-ideology" definition of populism of Cas Mudde[1] as a departure point and made use of the concepts of neoliberal populism and neopopulism that emerged in the literature on Latin America. Those components include an anti-establishment emphasis in terms of being critical of institutions, bureaucracy, and political parties; an anti-elite emphasis that defines the people as the rulers against the elites; one–man rule that emerges as a way of mobilization; the negation of intermediary political institutions between the people and the leader; and the leader's identification with the people by emphasizing being one of them. Neoliberal populism emerged mainly to understand how the lower class people make up the majority of the constituencies of populist parties despite the neoliberal policies embraced by those parties. As this dissertation aimed to understand how and why the health reform in Turkey was embraced widely and became a basis over which the populist politics of the AKP was constituted despite the commodifying and privatizing consequences, neoliberal populism

1 Cas Mudde, "The Populist Zeitgeist,'" *Government and Opposition*, 39 no. 4 (2004): 542–63.

offered a conceptual frame to analyze this contradiction in the Turkish health scene.

Relying on these conceptual tools, the dissertation analyzed the political debate that was generated around health reform in Turkey between 2002 and 2011. By providing a close examination of both the pro and anti-reform discourse on health, it showed that a technical issue such as health care became a primary basis of political debate, contestation, and polarization in Turkey in the early 2000s.

Firstly, the dissertation examined the political discourse generated by the AKP and pro-government media around health care reform, focusing on the period from November 2002 until the 12th June 2011 parliamentary elections, which corresponds to the formative period of the political discourse and debate on health reform. The dissertation also analyzed how an oppositional discourse emerged on health care reform that contested the AKP's presentation of the HTP. It analyzed the anti-reform discourse formulated by social actors, consisting of professional associations and trade unions. It examined arguments raised by the leading contesting actor, the TTB, and others that joined it in voicing a public critique of the AKP's health reform policies.

This dissertation argued and demonstrated that the health reform in Turkey despite its neoliberal outcomes and agendas and resulting in commodification and privatization of health services had been embraced by the majority of the public as it had been packaged with a coherent populist framing. The health care was constructed as a key site of the AKP's populist politics. The dissertation also argued that, as the opponents base their objections and criticisms to this reform on the long-term consequences of the health care reform their discourse remained less strong face-to-face with the short term gains of the health care reform. In other words the two sides of this debate constructed their arguments on different temporalities, while the government's arguments – a characteristic of populist politics- reflect the short term immediate-to-experience, concrete consequences of the health-care reform, the ones of the opponents remained abstract and less convincing than that of the government.

The study demonstrated that health reform served as a primary site for the AKP to construct its broader populist discourse. In the AKP's populist dis-

course, serving the people, treating all citizens as equal, being just, representing a radically different approach from previous governments, and introducing a total change in the mentality of the country emerge as central themes.

This populist politics rests on a discursive opposition constructed between an "old Turkey" in which the AKP claims the citizens were victimized by elites and a "new Turkey" that the AKP offers to construct on the basis of equality.

In this broader political picture, health-care emerged as a key discursive space where the AKP's populist claims to end "old Turkey's" social inequalities and "victimizations" were materialized. Furthermore, the AKP's changes to the health system were presented as symbols of the creation of a "new Turkey" in which the previously-victimized people are saved from privileged elites.

In other words, it was not only structural changes that the AKP insistently introduced to the health system through the HTP but also its strong discursive determinacy to propagate these changes as an end to the inequalities of "Old Turkey" that created a rupture in Turkey's larger political field. That larger political field has been defined both by the AKP's populist politics as well as contestation to this populism, as reflected in the public debate on health reform that this dissertation analyzed.

As the preceding chapters discussed in detail, all critical components of populist political discourses, namely an anti-establishment emphasis, and anti-elite emphasis, and one-man rule, can be traced in the AKP's political emphasis on health reform.

The anti-establishment discourse is formed via how health services are improved by being extended to cover previously-excluded people. The regulations regarding the detainment of patients, the introduction of a general health insurance scheme, and improvements to the infrastructure of health care units in eastern provinces come forward as issues through which anti-establishment discourse emerges in the narratives of the AKP. Through these issues and by claiming to give priority to the endowment of equality and service of the people the AKP underscores what makes them different.

A one-man or strong leader component in which the leader identifies himself with the people emerges in health reform discourses, especially during electoral campaigns. This component of populism, as mentioned earlier in this

chapter, involves the formation of a direct relationship between the leader and the people without intermediary political institutions. In the case of health policy reforms, during the presentation of the general health insurance law and the earlier regulations regarding the common use of hospitals by people under different social security schemes, Recep Tayyip Erdoğan boldly underlined how as a former worker, he himself experienced the malfunctioning of the SSK system and the hospitals. Thus, he asserted that he understands the difficulties experienced by the people, and claims that as a consequence he prioritizes ensuring equality among people and serving the neglected masses. In addition the issue of general health insurance and the provision of health services to SSK-covered citizens in hospitals not previously available to them was also presented in reference to the leader of the main opposition party, Kemal Kılıçdaroğlu. As Kılıçdaroğlu was a former president of the SSK, Erdoğan's discourses on the general health insurance system identify himself with the people and Kılıçdaroğlu with the "old Turkey" in which the malfunctioning social security system caused deep-seated inequalities.

The anti-elite theme is also reflected in the discourses of the AKP: In the anti-elite discourse the main emphasis is the sharp division between the two groups, elites and the people. In the AKP's discourse this division is materialized in the divide constructed between doctors and the people and the clear-cut definition of doctors as elites. Furthermore doctors are portrayed in line with the ways "elites" are depicted by populist ideologies. As underlined in the populism literature, in populist politics "elites" as opposed to "the people" are characterized elites by corruption and impurity. In the Turkish case, this emphasis on elites' corruption and moral impurity manifests itself in the health area through the discussion of issues such as obligatory rotations, the anti-HTP position of the TTB, the full-time employment law, and the alleged demand for extra payments by doctors.

Most importantly, in highlighting the populist politics central to the AKP's discourse on health reform, this dissertation argues that the AKP's pro-reform discourse presented health care providers and health care receivers as opposing groups and positioned the AKP as the protector of health care receivers who did not receive services that they deserved in the pre-AKP period. This discourse claims that health care receivers were deprived of these services

mainly because health care providers (equated with doctors), like the country's other elites, prioritized their own interests rather than "serving" the people. Pro-government media's coverage of health reform complemented and reinforced the AKP's political discourse on health reform.

On the other side of the public debate on health reform, this dissertation analyzed the oppositional discourse that contested the AKP's presentation of the HTP. It analyzed an anti-reform discourse formulated by social actors, consisting of professional associations and trade unions. It examined the arguments raised by the leading contesting actor, the TTB, and others who joined them in voicing a public critique of the AKP's health reform policies. It highlighted the unique historical and political position of the TTB, which is central to understanding the content of the oppositional discourse it generated.

As discussed in preceding chapters, from its beginning the TTB functioned not only as a professional association centered on the protection of professional rights and the definition of professional practices but also as an organization responsible for public health and the equivalent of a union for doctors.

Its corresponding, oppositional discourse on health reform primarily claimed that the reform would pave the way for the privatization and commodification of health services, negatively affecting both health care receivers and providers in the long run.

However, both because of the short-term gains of the HTP for health care receivers and the coherent "New Turkey" narrative of the AKP that framed the government's presentation of the HTP, the discourse of the opponents, namely the TTB, was less dominant and less visible than that of the government.

In the end, the receivers versus providers split prevailed in the public debate on health reform. The discursive opposition constructed between the receiver-citizens and provider-doctors took a particular turn when the full time employment law was put on the agenda in 2010 introducing restrictions on the working arrangements of doctors in the public sector. With this agenda, the public debate around a health reform that was a major restructuring with consequences for an entire population came to be framed more boldly as a

struggle between the government and contesting actors, mostly doctors represented by the TTB.

To conclude, the focus of this study has not been the dynamics of the formulation of health reform policy in Turkey or its consequences, which are already the subject of sophisticated analyses in the literature. Rather, the study uses the political debate on health reform as an analytical lens through which to understand the populist narrative and politics of the AKP and the political polarization that emerged as a consequence. Thus, the study contributes to scholarly debates on the populism of the AKP and the political polarization of Turkey in the 2000s.

The dissertation also contributes to sophisticated analyses on health reform in Turkey by highlighting the political dimension of health reform. Relatedly, the study demonstrated how the AKP's discourse on health reform depended on pitting two groups - health providers and receivers - against each other. For this, the analysis traced how two reform trends identified in the literature on Turkish health reform- universalism and marketization -were taken up and foregrounded by various, contending actors and used in the political discourse and debate on health reform.

A few words of caution are appropriate before concluding. In analyzing the discursive dimension of health reform, this dissertation does not imply that health reform policy was merely a discourse. On the contrary, it is important to acknowledge the concrete, actual changes introduced through the HTP. The AKP's discursive emphasis on extending coverage, for example, can be verified statistically. So, can the TTB's claim that the health reform would pave the way for marketization.

To start with the latter-marketization-, there was a significant increase in the number of private hospitals after the launch of the HTP. Private hospitals in 2002 accounted for 271 - or 23.4 percent - of the 1156 hospitals in the country. By 2016, the number of private hospitals reached 565 - 37,4 percent of 1510 hospitals. In the same period public hospitals (those belonging to the Ministry of

Health and university hospitals) decreased from 71.2 percent of the total in 2002 to 62.5 percent in 2016.[2]

Another aspect of marketization was the introduction of the split of providers and purchasers. The state became a purchaser of health services from the private sector, and an internal market was created wherein public hospitals compete with private hospitals. As noted by Eder, the share of social security health expenditures received by private hospitals rose by 64% in the 2002-2007 period.[3] The share in December 2017 was 20.3 percent.[4] Besides the statistics mentioned above that point to the marketizing impacts of the health care reform I would like to draw attention to two other major neoliberal outcomes of the health care reform that emerge as two topics that occupy the agenda of the TTB as significant consequences of the health transformation program: the violence towards the doctors and the "city hospitals."

The violence towards the doctors as discussed in the Chapter 8 is an issue that TTB underscores frequently as a significant consequence of the health transformation program. Their main arguments rest on how the increased work-load of the doctors result in the worsening of the services they provide, shorten the time they devote to each individual patient. According to TTB, the increased work-load of doctors intertwined with the government's framing of the doctors and the people as opposing sides make the doctors the sole target of frustration of people when they encounter a discrepancy between the promised health services by the government and the actual practice in the field.

The opinions and the solutions offered to violence against the doctors by TTB and the Ministry of Health differed considerably. This difference reflected the diverging opinions of the two sides regarding the health reform. In the

2 Sağlık Araştırmaları Genel Müdürlüğü, (General Directorate of Health Research) "T.C Sağlık Bakanlığı Sağlık İstatistikleri Yıllığı 2016," (Ministry of Health 2016 Health Statistics Almanac) (Ankara: Ministry of Health,2017), 101.

3 Mine Eder, "Retreating State? Political Economy of Welfare Regime Change in Turkey" *Middle East Law and Governance* 2, no. 2 (January 2010): 170-171. https://doi.org/10.1163/187633710X500739.

4 SGK (Social Security Institution), Monthly Statistical Bulletin, Health Statistics, Billing Information according to the type of Health Service Provider, December 2017.

earlier years of the health reform the TTB argued that violence against doctors increased considerably and proposed a law change that would protect the doctors from violence and demanded the formation of a research commission in the parliament to work on this issue. Government rejected those demands with the explanation that the violence towards the doctors are individual cases.[5] Following the murder of the Ersin Kalaycı in 2012 a research commission was established in the parliament, and the Ministry of Health introduced a unit called "White code" in the ministry that is devoted to give legal consulting to the doctors who experienced violence. According to TTB these initiatives would not resolve the violence issue as the root of the problem lies in the changing working conditions of the doctors and the deterioration of the health care system as a consequence of the health transformation program. Additionally TTB frequently mentioned that without legal changes that introduce sanctions for the violent acts committed to the health personnel, the violence issue would persist in the long run. [6] Lastly in November 2018 a law concerning the sanctions for violence in health sector has passed. TTB openly criticized the article emphasizing that it is far from being deterrent against crimes concerning the health personnel[7] as opposed to the law draft they proposed. TTB in 2014 proposed a law draft which consisted of heavy sanctions for the crimes against the health personnel such as life sentence in case of an act of violence that results in death and 3 to 5 year imprisonment in case of threatening a health personnel while performing their job.[8] The criticisms over the law, the proposition of a law article regarding the violence by the TTB show that the violence issue in health sector remain to be a problem for the health sector employees which they define as a direct result of the health reforms executed by the AKP.

City hospitals project (Şehir Hastaneleri) is another issue that stands out as a neoliberal outcome of the health transformation program. TTB founded

5 "Yaşasın: Sağlıkçıyı Kasten Yaralayan (Artık) Yakalanacak! Sonra?" Bianet, November,1 2018.

6 "Sağlıkta Şiddet Yasası için Kaç Hekim Ölmeli?" Bianet, October, 12 2018.

7 "Yaşasın: Sağlıkçıyı Kasten Yaralayan (Artık) Yakalanacak! Sonra?" Bianet, November, 1 2018.

8 Fikret İlkiz, "Cambaza Bak ve Kanun Teklifleri," Bianet, November 19, 2018, https://bianet.org/kadin/bianet/202732-cambaza-bak-ve-kanun-teklifleri.

a "City Hospitals Monitoring Group" in 2017 that would regularly visit the city hospitals, examine the financial structure and working conditions of the doctors and health employees. In their own words TTB aims to understand how the city hospitals would transform the health services.[9] City hospitals project is the latest outcome of public private partnership in health sector. The first legal step regarding the public private partnership in health care sector was made in 2005. The law article introduced into the Law no. 5396 regarding "Health Care Services" allowed the Ministry of Health or National Treasury to rent land or properties to people or legal entities in order them to establish health care units.[10] Following this in March 2007 legal change AKP proposed a draft law to parliament on "Pilot Project of Public Hospital Unions" details of which are discussed in detail Chapter 7. The draft law proposed uniting the secondary and tertiary health institutions under public hospital unions. The law described the public hospital unions as institutions who are administratively and financially.[11] "The Public Hospital Unions" were annulled with the statutory decree no. 694 on 25 August 2017. The annulment is explained by Tükel as a consequence of the increasing debts of the Ministry of Health Hospitals indicated in the audit report of the Turkish Court of Accounts.[12]

Following this annulment in 2017 city hospitals which are based on the private-public partnership model were established. Initially this project was named as "integrated health campuses." City hospitals are health units whose construction is realized by private companies that win the bidding process. These companies are granted the land over which they build the company at no charge and upon the completion of construction Ministry of Health rents

9 "TTB Şehir Hastaneleri İzleme Grubu Kuruldu," TTB, May 15, 2017, http://www.ttb.org.tr/kollar/_sehirhastaneleri/haber_goster.php?Guid=72a3d884-d8f7-11e7-ab27-5e59a11fb42d.

10 "Sağlık Hizmetlleri Temel Kanununa Bir Ek Madde Eklenmesi Hakkında Kanun, Kanun No: 5396," July 3, 2005, http://www.resmigazete.gov.tr/eskiler/2005/07/20050715-2.htm.

11 Raşit Tükel, "Sağlıkta Dönüşümde Son Dönem: Şehir Hastaneleri," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 210.

12 Ibid, 214.

those health units from the construction company.[13] As of 2019 there are 9 city hospitals that are completed and running and 8 city hospitals are under construction. City hospitals use public-private partnership model. In this model the public services are delivered by public and private entities. State gives certain privileges to private sector to facilitate investments, the most recent examples of public private partnership model in Turkey in addition to city hospitals are Osmangazi Bridge, Third Bosphorus Bridge and Eurasia Tunnel.[14] The legal regulations regarding the public private partnership model gradually granted more and more privileges to the private sector. Some examples of which are: In 2011 with the statutory decree no 663 Ministry of Health was given the autonomy to make decisions over the health unit investments that are up to 20 million Turkish Lire; The companies which win the bid of public private partnership are held exempt from value added tax in 2012; In order to build a city hospital in Trabzon a change in the coastal law was accepted in the parliament in 2017; the ban on providing credit from abroad in foreign currency for the private companies were abolished in 2017.[15] These legal encouragements, exceptions and exemptions render the investments in city hospitals for the private sector.[16] As the contracts signed between the Ministry of Health and the companies are liable to private law instead of administrative law the sum to be transferred to the companies is under the confidential business information category, and cannot be disclosed to public which prevents to reach

13 Kayıhan Pala, "Sunuş," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 9.

14 Raşit Tükel, "Sağlıkta Dönüşümde Son Dönem: Şehir Hastaneleri," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 215-216.

15 "Türkiye'de Şehir Hastanelerinin Kronolojisi," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 319-321.

16 Çiğdem Toker, "Bütçeyi Hasta Eden Bir Sağlık Modeli: Şehir Hastaneleri," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 255.

those contracts and make comparisons between the sums transferred to public and private sector.[17]

TTB took the city hospitals project on its agenda through the aforementioned working group and made observations in some of the city hospitals. The general problems they point to are; financing method, choice of location, the transportation problem to the city hospitals by the people (as a consequence of the closure of hospitals in the city centers), the situations of the buildings and lands of those closed hospitals in the city centers (the possibility of their transfer to companies who win the bid to build the city hospitals in that province), the employment situations and personal benefit problems of the health employees in the city hospitals.[18] These two main issues that occupy the agenda of TTB exemplify marketizing consequences of the health transformation program. The city hospitals project with its financing model and the privileges it provides to its investors stands at the opposite extreme of the justice and equality discourse with which the health transformation program was framed by the government since its launch.

However, as mentioned several times in the dissertation, the equalizing impacts of the health transformation program that come up very frequently in the discourses of the government are far from being a discursive frame. As for coverage which is continuously highlighted within AKP discourse, statistics reveal that coverage has expanded significantly following the HTP. In 2002, statistics on those with health care coverage were as follows: 33.4 percent of the population was covered by SSK (active and retired), 12.5 percent by Emekli Sandığı (including active state employees), 11.7 percent by BAĞKUR (active and retired), 8.6 percent by the Green Card Scheme, and 1% by private insurance and other schemes and 32.8 percent were not covered.[19] By 2016, on

17 Raşit Tükel, "Sağlıkta Dönüşümde Son Dönem: Şehir Hastaneleri," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 221.

18 Kayıhan Pala, "Sunuş," in *Türkiye'de Sağlıkta Kamu-Özel Ortaklığı: Şehir Hastaneleri,* ed. Kayıhan Pala (İstanbul: İletişim Yayınları, 2018), 11.

19 Türkiye Ulusal Sağlık Hesapları Hane Halkı Sağlık Harcamaları 2002-2003, Refik Saydam Hıfzısıhha Merkezi Başkanlığı, 2006, 16.

the other hand, insured people, pensioners, and dependents constituted 85.5 percent of the population. In addition with those whose premiums are paid by the state and themselves making up 12.8 percent of the population, the coverage percentage sums up to 98.3 percent which leaves 1.7 percent of the population uncovered in 2016.[20]

The number of hospital visits have also increased, which is reflected in the statistics. There were 110 million visits to Ministry of Health hospitals in 2002, which amounts to 1.58 visits per person. This number reached 340 million by 2016, corresponding to 4.3 visits per person. Visits to private hospitals rose from 5.6 million in 2002 to 71 million in 2016. The number of hospital beds in Turkey in 2002 was 107,394, and this number rose to 132,391 by 2016,[21] public expenditure in health in 2002 was 18.7 million lire, which corresponded to 5.2 percent of the gross national product. In terms of a percentage of GDP, this peaked in 2007 at 5.8 percent. In 2016, the public expenditure was 119.7 million lire corresponding to 4.6 percent of the GDP.

Even though no large-scale research has been conducted looking at the impact of the voting behavior of AKP electors, satisfaction surveys of the Turkish Statistical Institute show that the percentage of people highly-satisfied with the public health services rose from 40 percent in 2003 to 71.7 percent in 2017, and public health institutions rose from being last among state institutions to second in terms of satisfaction.[22] Thus, it would not be unfounded to suggest that health services have an impact on voting for the AKP.

In this respect, it is crucial that future research focuses on the experiences of service receivers in the post-HTP period to more solidly explain health policy reform in Turkey. Additionally the daily experiences of doctors and other health sector employees would provide a rich resource from which to understand the everyday consequences of the HTP in the field.

20 SGK (Social Security Institution), Statistical Yearbook, 2016.

21 "Kamu Hastaneleri Genel Müdürlüğü, Genel Sağlık İstatistikleri," Sağlık Bakanlığı, http://rapor.saglik.gov.tr/istatistik/rapor/.

22 TÜİK (Turkish Statistical Institution), Survey on Satisfaction from Public Services 2003-2017.

Appendix A Chronology of HTP

Based on publications of the Ministry of Health

2002 Circular regarding the discharge of patients released which prevented patients from being held in pledge.

2002 Announcement of Emergency Action Plan by the government.

2003 Health Transformation Program was announced by the Ministry of Health.

2003 Performance-based supplementary pay system introduced.

2003 112 emergency health care services made free of charge.

2003 Regulation enabling citizens to access services provided by private hospitals and medical centers using their health insurance was enacted.

2004 Implementation of a personal performance-based payment system in Ministry of Health institutions.

2004 Outpatient services included in the benefits package of Green Card holders.

2004 Implementation of the right to choose a physician in Ministry of Health hospitals by the Ministry of Health.

2004 Implementation of a reference price system for medicine.

2004 [Health Information Communication Centre] SABIM was put into service.

2005 Enrollees from [social insurance agencies] SSK start to benefit from public hospitals by uniting public cost pools under a single roof.

2005 Green Card holders began to benefit from public health care services like other insured citizens and can purchase medicine from any pharmacy.

2005 Institutional and quality criteria included in performance-based payment systems in Ministry of Health institutions.

2005 Family medicine pilot implementation started in Duzce province.

2005 Introduction of Patient Rights unit in every Ministry of Health hospital

2005 Introduction of compulsory public service for physicians.

2005 Law No. 5283 on Transfer of Health Units of Some Public Institutions to Ministry of Health was passed.

2005 Ministry of Health issued the Circular on the Effective Provision of Health Services.

2006 Global budget implementation for Ministry of Health hospitals.

2006 Law No. 5502 on the establishment of SGK (Social Security Institution.) was passed.

2006 Law No. 5510 on the Social Insurance and General Health Insurance was passed.

2007 Access to primary care services free of charge.

2007 Termination of the referral obligation from Ministry of Health hospitals to university hospitals for SSK and Bağ-Kur [the Social Insurance Agency for Merchants, Artisans and Self-employed] enrollees.

2007 Implementation for SSI–contracted hospitals including the free supply of medicine and medical equipment (under insurance coverage) and sanctioning of hospitals receiving payment from patients.

2007 Expansion of coverage for Green Card holders to include medical examinations, outpatient services, test- analysis, medicine, dental extraction, dental prosthesis, eyeglasses, and emergency care.

2007 Procurement of ambulances with continuous tracks to provide accessibility to areas with dangerous winter conditions.

2008 Provision of emergency and intensive care treatments free of charge in all public and private hospitals.

2008 Procurement of the following services free of charge in private hospitals: burns, cancer, neonatal care, tissue transplantation, congenital anomalies, dialysis, and CVS [cardiovascular surgery] procedures.

2008 Inclusion of people aged 18 years and under and students in [universal health insurance] UHI coverage without seeking Social Security.

2008 All citizens, insured or non-insured, begin to benefit from free health care services for emergencies, epidemics, occupational accidents, and occupational diseases.

2009 Start of [Pharmaceutical Tracking System] PTS pilot implementation

2009 Start of the Central Patient Appointment System (CPAS) pilot implementation.

2010 Green Card holders start to benefit from emergency and intensive care services in private hospitals free of charge.

2010 Inclusion of ambulance airplanes in the air ambulance group.

2010 Law no. 5947 on the Full Time Employment of University Personnel and Changes to Some Laws was passed.

2011 Restructuring of the Ministry of Health with the decree on Organizations and Duties of the Ministry of Health and Associated Institutions.

2011 Central Hospital Appointment System (CHAS) was put into use.

2011 Statutory Decree No. 663 that allowed the recruitment of foreign doctors was published.

2012 Evaluation of the performance of the Public Hospitals Union and health facilities started as part of a broader study of the Public Hospitals Union.

2012 Health Tourism Action Report prepared in order to deliver high quality, cheaper health services for health tourism.

2013 Building process of seventeen comprehensive city hospitals in different regions started.

Appendix B List of Interviewees

- Ali Çerkezoğlu
- Bilal Yıldırım
- Atilla Özsever
- Eriş Bilaloğlu
- Ersoy Adıgüzel
- Köksal Aydın
- Mustafa Sütlaş
- Osman Öztürk
- Tufan Sertlek

Appendix C Quotations in Original Language

1 "Sağlıkta tam anlamıyla bir devrim yaptık. Vatandaşlarımızı sağlığından eden sağlıksız bürokrasiyi ortadan kaldırdık. SSK, BAĞ-KUR, Emekli Sandığı ayırımına son verdik. Tüm sağlık kuruluşlarını aynı çatı altında topladık. Hastanelerde geri çevrilme, rehin tutulma devrini sona erdirdik. Yeşil Kart uygulamasını daha da genişlettik." "Sağlıkta Tam Anlamıyla Bir Devrim Yaptık," *Türkiye Bülteni,* June 2011, 9. http://www.turkiyebulteni.org/PDF/70%20TB%20MAYIS%20HAZIRAN.pdf.

2 "Recep Tayyip Erdoğan, Hastanelerde rehin kalmanın bittiğini belirterek böyle bir ihbar aldığım anda ilk yapacağım iş olarak o doktoru rehin almak olacaktır, o anlayışı rehin almak olacaktır. Zira ben inanıyorum ki bu bir yanlış zihniyetin doktorlarımıza dayatmasıydı. hiçbir doktor bu yola tevessül etmeyecek dedi. Hiçbir doktorumuzu kendi tıp yeminiyle çalişitirmeyecek bir adımı da atmış bulunuyoruz." *Yeni Şafak.* 2004 "Hastanede rehin Devri Bitti," March 17, 2004.

3 "Hizmet bedelini karşılayamadıkları gerekçesiyle hastane idarelerince hastaların taburcu edilmemesi, bebek ve annelerin rehin bırakılması ve cenazelerin alıkonulması gibi olumsuz hadiseler ile karşılaşıldığından, hizmet bedelinin ödenmediği gerekçesi ile hiçbir sağlık kurumunda hastaların, bebek ve annelerin rehin tutulmaması veyahut cenazelerin alıkonulmayacaktır." "25521-2002/119 sayılı Taburcu İşlemleri Hakkında Genelge" 26.11.2002 "Circular no: 25521-2002/119 on Discharge Procedures."

4 "AK Parti'nin kullandığı popülist söylem yakın tarihi bir tarafı "halk" yani "ulusun gerçek sahipleri," diger tarafı ise "onların kalkınmasını istemeyen" ve "onları aşağılayan" düşmanlar olan bir mücadele olarak yeniden yazmaktadır. Bu söylem birincisinin temsilcisi ve ikincisinin karşısındaki tek güç olarak AK Parti'nin çeşitli alanlardaki politikaları için gerekli meşruiyeti sağlamakta, dahası kendisine karşı yapılan muhalefet için de bir koruma kalkanı oluşturmaktadır." Büke Koyuncu, 'Benim Milletim…' AK Parti İktidarı, Din ve Ulusal Kimlik (İstanbul: İletişim Yayınları, 2014), 175.

5 "Boito'nun da sınıf karakterini açık biçimde ortaya koyduğu üzere, neolibral popülüzm, neoliberalizmin sonucu yoksullaşmış emekçi kitleleri "en zenginler"in hegemonya projesine bağlayan bir kayış görevi görmektedir. Yine

bu eksende neoliberal popülizm kavram setini oluşturan neoliberalizm ile popülizmin yan yana bulunmasındakki çelişki, en yoksulun en zenginin hegemonya projesi içerisinde etkisizleştirilmesi ya da destek sınıf haline getirilmesindeki çelişki resmini tamamlamaktadır." Deniz Yıldırım, "AKP ve Neoliberal Popülizm" in AKP Kitabı: Bir Dönüşümün Bilançosu ed. İlhan Uzgel, Bülent Duru (Ankara: Phoenix, 2009), 81.

6 "Sağlıkta tam anlamıyla bir devrim yaptık.Vatandaşlarımızı sağlığından eden sağlıksız bürokrasiyi ortadan kaldırdık. SSK, BAĞ-KUR, Emekli Sandığı ayırımına son verdik. Tüm sağlık kuruluşlarını aynı çatı altında topladık. Hastanelerde geri çevrilme, rehin tutulma devrini sona erdirdik. Yeşil Kart uygulamasını daha da genişlettik." "Sağlıkta Tam Anlamıyla Bir Devrim Yaptık," *Türkiye Bülteni,* June 2011, 9. http://www.turkiyebulteni.org/PDF/70%20TB%20MAYIS%20HAZIRAN.pdf.

7 "Hiçbir sosyal güvenlik kurumunun şemsiyesi altında olmayan gariban vatandaşlarımızyın hepsini sosyal güvenlik şemsiyesi altyına almak amacıyla çıkarılan yasayı, maalesef Anayasa Mahkemesi kararıyla, uygulamaya koyamadık. Daha geçenlerde bu yasanın bazı maddelerinin iptali sonucu uygulamasının ertelenmesi nedeniyle bir ailenin başına gelenleri basından öğrendik. Bir üniversite hastanesinin bu gariban aileden alacağının peşine düşmesi soncu insan ahlak ve onuruna asla yakışmayacak bir duruma şahit olduk. Bir sağlık kurumu yöneticisi için inisiyatif kullanmanın beklendiği yerin daha neresi olabileceğini milletin vicdanına havale ediyorum. İktidarımızdan önce benzer hadiselerin Sağlık Bakanığına bağlı hastanelerde de yaşandığına sıkça şahit olduk. Ancak, Hükumetimizin bu konudaki tutumu son derece nettir: İnsanyı yaşat ki devlet yaşasın." "Antalya Milletvekili Osman Akman'ın, 14 Mart Tıp Bayramı ve Sağlık Haftası'na, ülkemizde hekimlik mesleğinin tarihçesine, sağlık sisteminde karşılaşılan sorunlara ve alınması gereken tedbirlere ilişkin gündem dışı konuşması" (Speech Delivered by AKP mp Osman Akman on Doctor's Day) TBMM Tutanak Dergisi, Cilt:150, 75. Birleşim, 14 March 2007: 7, https://www.tbmm.gov.tr/tutanaklar/TUTANAK/TBMM/d22/c150/tbmm22150075.pdf.

8 "Yıllardır Türkiye gündeminde olan hastanelerde rehin tutulma olayının, aldıkları bir dizi tedbirle tamamen ortadan kalktığını anlatan Akdağ, "Basın da yakından takip ediyor. Son birkaç haftadır, Türkiye'nin hiçbir hastanesinde

parası olmadığı için rehin kalan hasta yok. Bunun aksini yapanlar hakkında gereğini yapıyoruz." "Sağlık Bakanı Recep Akdağ: Hastanelerdeki rehin olayı bitti," *Zaman*, February 3, 2003, http://arsiv.zaman.com.tr//2003/02/03/haberler/h12.htm.

9 Artık kimse hastanede rehin kalmayacak' Bir kez daha söylemek istiyorum ki hastanelerde rehin kalmak tarihe karışacak. Bunun derdi ve çabasındayız. Aslında açık ve net söylemek lazım. Bir hastanın ve cenazenin hastanede tutulmasının bir izahı yoktur. Bu bir alışkanlıktır ve kraldan çok kralcılık yapmaktan ortaya çıkmıştır. Yaygın bir olay da değildir. Toplum vicdanını rencide eden bir husus olduğu için yankı buluyordu. Artık hiçbir hastanemizde bu olmayacak. "Artık kimse hastanede rehin kalmayacak," *Zaman*, December 6, 2002. http://arsiv.zaman.com.tr//2002/12/06/doguanadolu/h5.htm.

10 "Hiçbir vatandaşmız sağlık hizmetinden yoksun bırakılmayacaktır" ilkesi, AK PARTi iktidarının sağlık konusunda hareket noktası oldu. İlk olarak, hastanelerde hastaların rehin tutulmasına son verildi. Acil başvurularda sigorta ve ödeme işlemlerinden dolayı hastaların geri çevrilmesi ve ambulanslardan ücret alınması uygulamaları kaldırıldı. "AK İktidarın 4 Yıllık Sağlık Karnesi: Sağlıkta Dönüşüm Yılları," *Türkiye Bülteni* 47 (April 2007): 48. http://www.turkiyebulteni.org/PDF/47%20NISAN%202007.pdf.

11 "Herkes için sağlık sloganıyla yola çıktık ve hizmetimizin merkezine insanı koyduk. Sağlık, parası olanın da olmayanın da, fakirin de zenginin de, eğitimlinin de eğitimsizin de, kırsalda yaşayanın da, şehirde yaşayanın da herkesin hakkı. Biz de bütün vatandaşlarımızın sağlık hizmetlerine kolay erişmesi, kaliteli bir hizmet alabilmesi üzerine hedeflerimizi inşa ettik. Sağlıkta dönüşüm programını da bu ana temel üzerine oluşturduk. Siyasetimizi oluşturan ahlaki anlayışmız da her adımımızda temel bir unsurdur. Kırsal kesimde yaşadığı için Türkiye nüfusunun yaklaşık yüzde 30'u sağlık hizmeti almakta zorlanıyordu. Çünkü, ulaşabilmek için yol, ulaştığında hizmet verecek sağlık personeli, hepsinden de önemlisi bölge insanının sağlık hizmetlerine erişme ümidi yoktu." "Sağlıkta Dünya Markası Olmayı Hedefliyoruz," *Türkiye Bülteni* 56 (July-August 2008): 27.

12 "Türkiye'de personel dağılımıyla ilgili doğu-batı arasında ve şehir merkezleriyle ilçeler, köyler arasında büyük bir dengesizlikvar. Bununla ilgili çalışmalar devam ediyor; ama, yeterli olduğu kanaatini taşımıyorum. Birçok bölgemizde

daha hekim sıkıntısı,sağlık personeli sıkıntısı çekmekteyiz. Bunun ..zümüyle ilgili sözleşmeli statü getirdik; ama, yeterli olduğu kanaatini taşımıyorum.Mutlaka daha iyileştirici bir şeyler yapılması gerektiği kanaatini taşıyorum ve sözleşmeli hekimlere daha çok ücret vererek, belki-dönersermayeden veya başka alanlardan, daha çok, gidilmeyen yerlerdeki ücretleri artırmak gerektiği kanaatini taşıyorum." "Kars Milletvekili Yusuf Selahattin Beyribey'in Tıp Bayramı'na ilişkin konuşması" TBMM Tutanak Dergisi, Cilt:150, 70. Birleşim, 15 March 2005, https://www.tbmm.gov.tr/tutanak/donem22/yil3/bas/b070m.htm.

13 "Kendim de 20 yıl boyunca Erzurumda hekimlik yaptım, ben kendimi bildim bileli Doğu ve Güneydoğu bölgelerinde sağlık personeli sıkıntısı çekiliyor. Bu, 2004 Türkiyesi için kabul edilemez bir durumdur. Eleman temininde güçlük çekilen yerlere sözleşmeli personel atayarak sorunu çözmeye çalıştıklarını dile getiren Akdağ, Bir yıl içinde bölgeye 13 bin sağlık personeli gönderdik. Bu son 20 yılın rekor rakamıdır. Böylece yardımcı sağlık personeli sıkıntısı önemli oranda çözüldü. dedi. Bütün bunlara rağmen uzman doktor sıkıntısının devam ettiğine dikkat çeken Akdağ, şöyle konuştu: Uzmanlarımızın sözleşmeli personel uygulamasına ilgi göstermesi için net 3 milyar lira maaş önerdik. 500 milyon lira da ödül koyduk. Döner sermayeyle beraber bir uzman hekimin Doğuda 8 milyar kazanma imkanı var; ama gitmek istemiyor. Sözleşmeli Personel Yasasında teşvik unsurlarını daha da artırmak için bir çalışma yaptıklarını kaydeden Akdağ, bütün bu çalışmalara rağmen bölgedeki uzman doktor açığının kapatılmaması halinde kamuda çalışan uzman hekimler için uzun süreli rotasyon sistemini uygulayacaklarını kaydetti. Sağlık Bakanı, Kaymakamlar, savcılar, askerler her yerde çalışıyor. Ben hekimlerin de adilane dağıtılmış bir görevi kabul edeceklerine inanıyorum." "Doktorlar Doğu'ya Zorunlu Gönderilecek." *Zaman,* April 25, 2004. http://www.zaman.com.tr/gundem_doktorlar-dogu-ya-zorunlu-gonderilecek_40861.html.

14 "AKP 2007 Seçim Beyannamesi," June 2007, 79. www.akparti.org. "Bina, ekipman ve sağlık personelinin eksik olduğu bölgeleri öncelikli kabul ederek, bu konudaki dengesizlikleri büyük ölçüde ortadan kaldırdık. Kamuda yüz bine yakın yeni sağlık personeli istihdam ettik. Kamuya personel alımının son derece kısıtlı olduğu bir dönemde, alınan personelin önemli bir kısmını bu amaçla istihdam ederek, halkımızın yıllardır şikayetçi olduğu sağlık elemanı

sorununa büyük ölçüde çözüm getirdik. Yeterli bina ve ekipman ile sağlık personelini buluşturarak, yurdumuzun her köşesinde hizmetlerin ölçeğini ve kalitesini geliştirdik." "AKP 2007 Seçim Beyannamesi," June 2007, 79. www.akparti.org

15 "Temel bir hak olarak gördüğümüz sağlık hizmetlerini ayrım gözetmeden ve farklı uygulamalara meydan vermeden vatandaşımıza ulaştırıyoruz. Her vatandaşımız, üniversite hastaneleri ve özel hastaneler dahil, istediği her hastaneye gidebiliyor. Dar gelirli kesimlere yönelik olarak yeşil kartlı vatandaşlarımızın hakları genişletilmiştir. Yapılan düzenleme ile Yeşil Kart sahiplerinin "ayakta tedavi" kapsamında görecekleri sağlık hizmetleri ile ilaç giderleri de devlet tarafından karşılanıyor. SSK hastalarının ilaçlarını anlaşmalı serbest eczanelerden alabilmeleri imkanını getirdik. Böylece, milyonlarca çalışan ve emeklinin kuyruk çilesini sona erdirdik, hak ettikleri kalitede hizmet almalarını sağladık." "AKP 2007 Seçim Beyannamesi," June 2007, 77. www.akparti.org.

16 "Şöyle bir yapı düşünün, siz sigorta kurumunun personelisiniz. Sigorta kurumunun gösterdiği doktordan başkasına muayene olamazsınız. Gösterdiği hastaneden başka hastaneye gidemezsiniz.Gösterdiği eczaneden, kendi eczanesinden başka yerden ilaç alamazsınız. Sizi adeta bir kalıbasokmuş, biz bu kalıbı kırıyoruz. Hasta lehine kırıyoruz. Daha önce hayata geçirilen ortak kullanım protokolü ile zaten bunun büyük kısmı kırılmıştı. Bu uygulamanın ardından SSK'lı hastamız, işçi kardeşimiz devlet hastanesine gittiği zaman rahatsız mı oldu? Hayır. Aksine bu uygulama ile SSK'lı hastalar çok rahatladılar. İstedikleri sağık ocağına, devlet hastanesine gittiler. Memurlarımız da SSK hastanelerine gidebildiler. Uygulama hekim tercih etme özgürlüğüne de bir adım oldu. Düşünün Ankara'nın Haymana ilçesinde oturan bir işçi kardeşimizsiniz veya işçi kardeşiimizin yakınısınız. Farz edelim evinizin dibinde sağlık ocağı var. Siz bu sağlık ocağından yararlanamıyorsunuz. Siz de bu devletin bir vatandaşısınız, sağlık güvenceniz de var, niye yararlanmayasınız bundan? Bunun en doğal hakkınız olması lazım. Bu hakkı size AK Parti hükümeti olarak getirdik. Sağlık güvencesi olan herkes artık istediği hastaneye, sağlık ocağına gidebilmenin rahatlığını yaşıyor. Hastanelerin tek elde birleştirilmesindeki en büyük amaç da zaten hastalarımıza iyi hizmet sunabilmek." *Türkiye Bülteni* 21 (February 2005): 29.

17 "Bütün vatandaşların herhangi bir ayrıma tabi tutulmaksızın hakettikleri sağlık hizmetine kolay erişebilmelerini sağlayacak olan bu uygulama ile hizmet sunumunda verimlilik artırılacak, herkese eşit, hakkaniyetli, hızlı ve etkili bir sağlık hizmeti sunulabilmesinin önü açılmış olacak." *Türkiye Bülteni* 22 (February 2005): 22.

18 "37 milyon işçi, ailesi ve emeklileriyle birlikte 370 hastane ve dispansere mahkumdu. Hastaneleri tek çatı altında topladık. Vatandaşlarımızın sağlık sigortalarıyla bütün sağlık kuruluşlarından hizmet almasını sağladık. Artık bu 37 milyon kişi de bütün vatandaşlarımız gibi 2330 hastane ve tıp merkezi ile birlikte 6336 aile sağlığı merkezinden hizmet alabilmektedir." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org.

19 "Ancak iktidarların ömürlerinin kısa oluşu, koalisyon hükümetlerinin varlığı ve biraz önce söylediğim gibi hedefine tam olarak insanı koyamamış düşüncelerin iktidar oluşu, bunun hayatiyete geçmesini zorlaştırıyordu. Aynı konu Türkiye'deki karmaşık sağlık güvence sistemleri için de böyledir. Ülkemizde yıllar boyunca Sosyal Sigortalar Kurumu'na tabi hastaların Sağlık Bakanlığı'na bağlı hastanelerden yararlanması konuşulmuştur ama hiç kimse bunun için gerekli adımı atamıyordu. Biz çok kısa bir süre içerisinde bu adımı atabildik. Üç büyük ilimizde hastanelerimiz hep birlikte halkımıza ortak hizmet vermeye başladılar. Bildiğiniz gibi Eylül ayı içerisinde beş ilimizi daha buna dahil ettik. Önümüzdeki günlerde hastanelerimiz ve diğer sağlık kuruluşlarımız bütün halkımıza ortak hizmet verir hastaneler durumuna gelebilecektir. Kamuya ait bütün sağlık kuruluşları ve kurumları ortak olarak halkımıza hizmet eder hale gelecektir." *Türkiye Bülteni* 5 (October 2003), 41.

20 "Devlet ve özel sektör ile vakıf sektörünü bir araya getirerek, emeklisinden işçisine, Bağ-Kur'lusundan, yeşil kartlısına, herkesin bu hastanelerin tümünden istifade etmesini sağladık. Bu iş için sevda gerek, aşk gerek. Biz de o aşk, o sevgiyle bunları başarıyoruz." *Türkiye Bülteni* 48 (May 2007), 48

21 "Mevcut sağlık sistemimiz, kurumsal yapı, işleyiş, personel yapısı ve dağılımı itibariyle ihtiyaca cevap veremeyecek hale gelmiştir. Maalesef ülkemizde toplam nüfusumuzun ancak yüzde 81'i sağlık sigortası kapsamına alınabilmiş olup, geri kalan yüzde 19'luk bir kitlenin herhangi bir sağlık güvencesi bulunmamaktadır. Etkin, ulaşılabilir ve kaliteli bir sağlık sistemi, nitelikli bir toplum için vazgeçilmezdir. Devlet, herkesin temel sağlık ihtiyacını, gerekirse özel

sektörle işbirliği yaparak yerine getirmek zorundadır. Nitelikli bir sağlık hizmeti için; Devlet hastanesi, sigorta hastanesi, kurum hastanesi ayırımı kaldırılarak, hastaneler idari ve mali yönden özerkliğe kavuşturulacaktır. "58. Hükümet Programı," 2003, https://www.tbmm.gov.tr/hukumetler/HP58.htm.

22 "Başta Sosyal Sigortalar Kurumu hastaneleri olmak üzere, diğer kamu kurumlarının hastaneleri Sağlık Bakanlığına devredilmiştir. Artık her vatandaşımız, üniversite hastaneleri ve özel hastaneler dahil, istediği her hastaneye gidebilmekte, tercih ettiği doktora muayene olabilmekte, ilaçlarını anlaşmalı serbest eczanelerden alabilmektedir.Böylece, sağlık hizmetlerinden faydalanmada vatandaşlarımızın Emekli Sandığı mensubu, SSK'lı, Bağ-Kur'lu gibi ayrımlara tabi tutulması sona erdirilmiştir. Halkımızın tümünün sağlık hizmetlerinden aynı standartta faydalandığı, yoksulların primlerinin devletimizce karşılandığı, 18 yaşın altındaki çocuklarımızın tamamının sağlık güvencesi altında olduğu "Genel Sağlık Sigortası" sistemini hayata geçirdik. Hastaneleri tek çatı altında topladık ve vatandaşlarımızın sağlık sigortalarıyla bütün sağlık kuruluşlarından hizmet almasını sağladık." "60. Hükumet Programı," 2007, https://www.tbmm.gov.tr/hukumetler/HP60.htm.

23 "Devlet hastaneleriyle SSK hastanelerini tek çatı altında birleştirdik. Emekli Sandığı'na bağlı, sigortalı ve Bağ-Kur'lu tüm vatandaşlarımızın bütün hastanelerden yararlanmalarını sağladık. Tam gün yasasıyla vatandaşlarımızın ancak özel muayenehanelerden geçerek sağlık hizmeti alma uygulamalarına son verdik." Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012): 71.

24 Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012), 73. "Sosyal güvencesi olmayan vatandaşlarımız dahil herkesi genel sağlık sigortasına kavuşturduk. 18 yaşına kadar herkese ücretsiz sağlık hizmeti veriyoruz. Kişinin anne ya babası sigortalı olsun ya da olmasın, prim borcu olsun ya da olmasın 18 yaşına kadar herkesin her türlü sağlık hizmetinden şartsız yararlanmasını temin ettik."

25 "AK PARTİ iktidarı mevcut sağlık kapasitesini etkili ve verimli kullanmak için kamuya ait tüm sağlık tesislerini tek çatı altında topladı. Bu sayede, sadece 150 hastaneden hizmet alan 30 milyondan fazla SSK'lı vatandaşımız, tüm devlet hastanelerinden ve sağlık ocaklarından yararlanma hakkına kavuştuğu gibi, gece yarılarına kadar ilaç kuyruklarında beklemekten kurtarılıp ilaçlarını

serbest eczanelerden alabilir hale geldi. Ayrıca memur, emekli, dul ve yetimlere özel sağlık kuruluşlarından yararlanma imkanı getirildi." *Türkiye Bülteni* 47 (July-August 2008), 49.

26 SSK ve devlet hastanelerini birleştireceklerini söylediklerinde CHP'nin, "Olmaz" dediğini anlatan Başbakan Erdoğan, "Biz ne dedik, 'olur' dedik ve oldu. Bakınız dünden itibaren hastanelerde ayrımcılık kalktı. Artık emeklisi,SSK'lısı, BAĞ-KUR'lusu, yeşilkartlısı bu ülkenin bütün hastanelerinden ayrım yapmadan istifade edecektir" dedi" "Biriz Beraberiz," *Türkiye Bülteni* 50 (July 2007): 18-19. http://www.turkiyebulteni.org/PDF/50%2007%20Temmuz%202007.pdf.

27 "74 milyon vatandaşımız acil ve yoğun bakım gerektiren hallerde özel hastaneler dahil hiçbir ücret ödemeden tedavi olabiliyor. Ayrıca sigortalı olsun veya olmasın herkesin salgın hastalık, iş kazası ve meslek hastalığı durumlarında her türlü sağlık yardımından ücretsiz yararlanmasını sağladık. Diğer taraftan özel hastanelerde yanık, kanser, yenidoğan, organ nakli, diyaliz ve kalp damar cerrahisi işlemleri için artık vatandaşımız ödeme yapmıyor." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org.

28 vatandaşın sağlık hizmetine hem kolay, hem de maddi sıkıntı çekmeden erişilmesinin sosyal devletin gereği oldu. Bir özel hastaneye acil durumda götürmüş bile olsa hastamız, bundan kimse para talep edemez. Acil bir hastamız, bir özel hastaneye bile götürülmüş olsa bu hastadan hiç kimse para talep edemez. Eğer ediliyorsa kural ihlali yapılıyor demektir. Vatandaşımız böyle durumlarda kendini mağdur görmesin. Hiç kimse vatandaşımıza bu hizmetler için senet imzalatamaz vatandaşa, söylediğim acil durumda para ver de tedavi edeyim diyemez." "Özel Hastanelerin Acil Hizmeti Ücretsiz," *Türkiye Bülteni,* (November-December 2010), 5.

29 "Hizmet bedelini karşılayamadıkları gerekçesiyle hastane idarelerince hastaların taburcu edilmemesi, bebek ve annelerin rehin bırakılması ve cenazelerin alıkonulması gibi olumsuz hadiseler ile karşılaşıldığından, hizmet bedelinin ödenmediği gerekçesi ile hiçbir sağlık kurumunda hastaların, bebek ve annelerin rehin tutulmaması veyahut cenazelerin alıkonulmayacaktır." "25521-2002/119 Sayılı Taburcu İşlemleri Hakkında Genelge," 26.11.2002 "Cir-

cular no: 25521-2002/119 on Discharge Procedures" http://www.istanbulsaglik.gov.tr/w/mev/mev_gen/tedavi_hiz/taburcu_islemleri_Hakkinda_Genelge.pdf.

30 "Yaratılanı severiz yaradandan ötürü anlayışı ile sağlıkta insan odaklı bir hizmet sunduk. Ak Parti siyasetinin temel ilkesi olan "millet hizmetkarlık" anlayışı ile hareket ettik. Bazı merkezlere karşı değil bizzat milletimize karşı kendimizi sorumlu hissederek davrandık." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 82, www.akparti.org.

31 "Sağlıkta tam anlamıyla bir devrim yaptık.Vatandaşlarımızı sağlığından eden sağlıksız bürokrasiyi ortadan kaldırdık. SSK, BAĞ-KUR, Emekli Sandığı ayırımına son verdik. Tüm sağlık kuruluşlarını aynı çatı altında topladık. Hastanelerde geri çevrilme, rehin tutulma devrini sona erdirdik. Yeşil Kart uygulamasını daha da genişlettik." "Sağlıkta Adeta Devrim Yaptık," *Türkiye Bülteni*, 70 (May-June 2011): 9, http://www.turkiyebulteni.org/PDF/70%20TB%20MAYIS%20HAZIRAN.pdf.

32 "İktidarımızdan once vatandaş ambulansla hastasını naklettirirken para öderdi. Köylerimiz için ambulans hizmeti yoktu. Şimdi köylerimize kadar hatta gerektiğinde 20 hava ambulansından biri ile tamamem ücretsiz olarak ulaşan ambulans hizmeti veriyoruz." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 84, www.akparti.org.

33 "AK PARTi iktidarının özel önem verdiği 112 acil istasyonu ve bu hizmetten faydalanan kişi sayısında 3 kata yakın artış sağlanırken, kırsal kesimin yüzde 95'i bu imkandanyararlanır hale geldi." "AK İktidarın 4 Yıllık Sağlık Karnesi: Sağlıkta Dönüşüm Yılları," *Türkiye Bülteni* 47 (April 2007): 49. http://www.turkiyebulteni.org/PDF/47%20NISAN%202007.pdf.

34 "Hali hazırda özellikle İstanbul, Antalya ve Gaziantep'te kısmen Ankara'da yurt dışından gelen hastalar var. Yani turistler dışında özellikle sağlık için gelenler var. Alan olarak da göz, ortopedi, kardiovasküler cerrahi ve diş hekimliği özellikle dikkat çekiyor. Ancak burada bir handikapımız var. Türkiye'deki doktor sayısı ve hemşire sayısının yetersizliği. Türkiye'de doktor sayısı ihtiyacın yarısı, hemşire sayısı ise 5'te biri kadar. Özellikle, sağlık turizminin önünü açmak istiyorsak, yurt dışından eleman çalıştırılmasına izin vermemiz gerekiyor. Biz kontenjanları artırmaya başlarsak ve yurt

dışındandoktor gelmesinin önünü açarsak önümüzdeki 3-5 yıl içinde kısmen bu ihtiyacı karşılarız. 2023 artık tam düzlüğe çıktığımız bir alan olarak görülebilir." *Türkiye Bülteni* 56 (July-August 2008): 31.

35 "Sağlık Bakanı Recep Akdağ, 53 Avrupa ülkesi arasında doktor başına düşen hasta sayısında sondan ikinci ülke olduğumuzu söyledi. 52 Avrupa ülkesinde 100 bin kişiye 280 doktorun düştüğünü Türkiye'de ise 100 bin kişiye 140 doktorun düştüğünü dile getiren Bakan Akdağ, şöyle konuştu: "Biz bu 52 ülke içerisinde de sonuncu sıradaydık şimdi sondan ikinci sırada olduk. Bir defa bu rakamlar Türkiye'de hekim sayısının yetersiz olduğuna işaret ediyor. yıllık muayene sayısıyla kıyasladığımız zaman da bir hekimin karşısına günde 50 kişi, 60 kişi hatta 70 kişinin çıktığını görüyoruz.Takdir edilmelidir ki bu sayılar çok yüksek. Dolayısıyla hem vatandaşımız için sıkıntı oluşuyor hem de doktorlarımız için sıkıntı oluşuyor. Ülkede bu kadar gencimiz üniversite okumayı beklerken ve bu kadar da doktora ihtiyaç varken hakikaten yeterli doktor yetiştirmemek ülkenin geleceği açısından çok büyük bir yazıktır. Mutlaka doktor sayımızı artırmalıyız.Birilerinin düşündüğü, iddia ettiği, değerli meslektaşlarımızı korkuttuğu gibi Türkiye'de doktorlar hiçbir zaman işsiz falan da kalmayacaktır. Onunu için de mutlaka doktor sayımızı artırmalıyız.Önümüzdeki yıl da Türkiye'nin en önemli sağlık meselesi doktor sayısındaki eksikliktir. Bu hususta da YÖK'ü göreve davet ediyorum. Çünkü hem yetki hem sorumluluk bu noktada YÖK'tedir." "Akdağ, Hekim Açığı İçin YÖK'ü Göreve Çağırdı," *Zaman,* December 17, 2006. http://www.zaman.com.tr/gundem_akdag-hekim-acigi-icin-yoku-goreve-cagirdi_473338.html.

36 "Daha önce de sözleşmeli personel kamuda çalıştırılıyordu ama çok sayıda personelin bir sistem olarak, eleman temininde güçlük çekilen yerlerde kullanılmaya başlanması Türkiye'de ilktir. Bu aslında bizim Kamuda Yeniden Yapılanma, Mahalli idarelerde Yeniden Yapılanma ve Personel Rejiminde Yeniden Yapılanma konusunda da attığımız en önemli adımlardan birisidir diye düşünüyorum. Burada ne yapıyoruz? Sağlık personeli çalıştırmakta zorluk çektiğimiz bölgelerde sözleşmeli, çakılı kadroları ihdas ediyoruz. Çakılı kadro ne demek? O pozisyona sözleşmeli olarak başlatılan hekim veya diğer yardımcı sağlık çalışanı oraya başlarken ilgili noktada çalışmak üzere başlıyor. Sözleşmesini bu şekilde yapıyor. Üç-beş gün sonra bir yolunu bularak başka

bir yere tayinle gitmeye şansı yok. Kendisi seçtiği yeri de, alacağı ücreti de biliyor. Üstelik daha dolgun ücret alacağını da biliyor ve kendi rızasıyla giderek orada verimli bir hizmeti vermesi için önü açılmış oluyor." *Türkiye Bülteni* 5 (October 2003): 43.

37 "Birileri tarafından sloganlarla konuşulur hale getirildiğini" ifade etti. Türkiye'de sağlık turizmi gelişmeye başladı. Türkiye'ye dışarıdan hastalar gelip, tedavi olmaya başladı. Zaten bize yetmeyen hekimler, bir de sağlık turizmi için istihdam edildiğinde biz ne yapacağız? Bu kadar yetersiz doktor sayısı olan bir ülkede doktorlarımızı bir de sağlık turizminde kaybedersek, çok sıkıntı çekeriz. Dışarıdan gelecek doktorlar bu hususta önemli bir eksikliği tamamlayabilirler. Biz, Türkiye'de hekim eksikliğinin tamamlanması için de sadece yabancı doktorların çalışmasını ön görmüyoruz. Mutlaka tıp fakültelerindeki öğrenci sayısı artırılmalı. Yabancı doktor gelmesin diyenler, bu işe muhalefet edenler, maalesef Türkiye'deki doktorların sayısının da azalmasını istiyorlar. Artmasını kabul etmiyorlar. Çok yaman bir çelişkidir. Acaba, Avrupa'da hatta dünyada (başka ülkelerin doktorları gelip, bizde çalışmasın) diyen başka bir ülke kalmış mı? Hangi asırda yaşıyoruz?" "Akdağ: Yabancı Doktor Gelmesin Diyenler Doktor Sayısı Azalsın İstiyor," Sondakika, February 17, 2007, http://www.sondakika.com/haber/haber-akdag-yabanci-doktor-gelmesin-diyenler-doktor/.

38 "Bir gazetecinin, veto kararındaki yabancı hekimlerin istihdam ve dil sorunlarıyla ilgili ifadeleri hatırlatması ve, "Siz de bu endişeleri taşıyor musunuz?" sorusu üzerine Akdağ, şöyle yanıt verdi: "Ben işimi yapıyorum. Sabah 05.00'te kalktım. 06.00'da Burdur'a geldim. Şimdi saat gece yarısına yakın. İşimi bu şekilde yapmaya devam edeceğim. Hükümetimiz, bu dönüşüm programını gerçekleştirmeye kararlıdır. Biz işimizi yapıyoruz. Dolayısıyla şöyle yorumlanmış, böyle yorumlanmış, bunlar bizi çok da doğrusu meşgul etmiyor." "Hükumetin Yabancı Doktor Kararlılığı," March 3, 2007, http://www.aktifhaber.com/hukumetin-yabanci-doktor-kararliligi-104383h.htm.

39 "Sağlık Bakanlığı'ndan dün akşam yapılan açıklamada yabancı doktor çalıştırılmasıyla ilgili bir fikir değişikliği olmadığı bildirildi. Açıklamada, şunlar kaydedildi: "Ancak, vatandaşlarımıza verilen sağlık hizmetlerinin kalitesinin artırılması için onaylanan maddelerin bir an önce yürürlüğe girmesini

arzu ediyoruz. Bunun için, meclisimize yeniden görüşülmek üzere iade edilen maddelerin, bilahare değerlendirilmek üzere kanun metninden çıkarılması, tarafımızca da uygun bulunmuştur." "Yabancı Doktorda Farklı Açıklamalar," *Milliyet*, March 9, 2007. http://www.milliyet.com.tr/2007/03/09/siyaset/axsiy02.html.

40 "YÖK Başkanı değişikliğine kadar biz eski YÖK Başkanı ile bu konuları görüşemiyorduk dahi. Doktor sayısının fazla olduğuna dair genel kabul vardı ülkede. Hastalara hizmet verecek doktor sayısının fazla olması lazım. YÖK'ün durumun ciddiyetinin farkına varmasının ardından tıp fakültelerine alınan öğrenci sayısı artıyor. DPT ve YÖK bunu anladı artık. Bu konuda adımlar attık. 2023 yılında ancak doktor sayımız yeterli olacak. Orta ve uzun vadede kendi personelimizi yetiştirmeliyiz. Kısa vadede bu işi başka yönlere çekmeden yurt dışından sağlık personeli getirilmesinin önünün açılması lazım." "Bakan Recep Akdağ: Yabancı Doktor Şart," Haber7, October 24, 2010, http://www.haber7.com/genel-saglik/haber/648519-bakan-recep-akdag-yabanci-doktor-sart.

41 "Başarılı bir "sağlıkta" dönüşüm programına karşın Türkiye'de sağlık insan gücü sayısında yetersizlik olduğunu kaydeden Akdağ"Ayrıca 1920'lerden kalma bir kanunda da Türkiye'de Türk vatandaşı olmayan doktorların çalışması yasak. Bunu kaldırmaya çalışıyoruz, Türkiye'deki ulusalcı tavırlar buna engel olmak istiyorlar ama bunu gerçekleştirmek zorundayız. Türkiye'deki halkın da küresel bilimden ve bilimadamlarından yararlanma hakkı olduğuna inanıyoruz" diye konuştu." "Yabancı Doktor Almak Zorundayiz," *Gazeteport*, September 29, 2011, http://www.gazeteport.com/haber/54904/yabanci-doktor-almak-zorundayiz.

42 "Tıp fakültelerinin son dört yıllık puanları sürekli olarak artıyor, talep fazlalılığından dolayyı puanlar artıyor. Biz, burada, şu yüce Meclisin çatısı altında milletin vekilleri olarak, bu işte sorumluluğu olan kurumları göreve çağırmalıyız. Ben, birçok kereler bu sorumluluğu hatırlattım, bir kere daha 14 Mart itibarıyla, 14 Mart Tıp Bayramı'nı vesile kılarak bir kere daha bu sorumluluğu hatırlatıyorum, Yüksek öğrenim Kurumuna özellikle bu sorumluluğunu hatırlatıyorum.Türkiye'mizde hekim sayısı ziyadesiyle yetersiz. Dünya Sağlık örgütünün Avrupa bölgesinde 53 ülke var. bu 53 ülkenin içerisinde, nüfusuna göre hekim sayısını kıyasladığımızda,Türkiye Cumhuriyeti

52'nci sıradadır. Evet, bir meslek örgütü yirmi senedir yaptığı bir yanlışı yapıp, hâlâ, 2006 yılının sonunda yayınladığı bir raporda "Türkiye'de tıp fakültesi öğrenci sayısı fazladır, acilen azaltılmalıdır." diyebilir, böyle bir yanlış yapabilir; ama, lütfen, bu yanlışı bu yüce çatının altında yapmayalım, ülkemizin geleceğini konşuyoruz. Türkiye Cumhuriyeti'nin insanları, Türk halkı, bu 53 ülkenin halkından, sağlık hizmetine daha az layık bir halk mıdır ki, bizim hekim sayımız, bu sayının en altında kalsın? Bu sayı eksikliği, bugün, bütün hekim arkadaşlarımın karşısına, çok büyük bir iş yükü ve risk çıkarmaktadır. Ne kadar verimli biçimde çalışırsak çalışalım, hekimler olarak ne kadar fedakârca çalışırsak çalışalım, bu iş yükü çok fazla. Onun için, ben, ana muhalefet partimizden de bu hususta destek bekliyorum. Türkiye'de hekim sayısını mutlaka artırmalıyız." "Recep Akdağ'ın 14 Mart 2007 Tarihli Konuşması," March 14, 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm.

43 "Sayın Cumhurbaşkanımızın geriye iade ettiği maddeler içinde, klinik şef ve şef yardımcılarının atamalarıyla ilgili bir madde de vardı. Bu maddeyi değerli milletvekillerim dikkatle okurlarsa şunu görecekler: bir tıp fakültesinin rektörlüğüne ve dekanlarına verilen öğretim üyesi oluşturma hakkı Sağlık Bakanlığına verilmek istenmiyor. Bunun önüne çıkarılan her engel, millete verilen hizmetlerin önüne çıkarılan engellerdir. Siz burada milleti temsil ediyorsunuz. Dolayısıyla, milletin vekillerinin iktidara getirdiği, güvenoyu vererek iktidara getirdiği hükümetin icraatlarını milletin adına yapılan icraatlar olarak siz de benimsemelisiniz." "Recep Akdağ'ın 14 Mart 2007 Tarihli Konuşması," March 14 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm.

44 "1999-2002 yılları aras›nda 39 bin sağlık personeli istihdam edilirken, 2003-2006 döneminde bu sayı 61 bin olarak gerçekleşti. Mahrumiyet sebebiyle yıllardır sağlık personel gönderilemeyen sağlık tesislerimize 16 bin sözleşmeli sağlık çalışanı tayin edildi. Yeni "Atama ve Nakil Yönetmeliği" ile bölgeler ve hizmet grupları oluşturularak adil bir personel dağılımı imkanı getirildi. Hizmet puanı kriterleri belirlenerek personel nakilleri objektif bir esasa bağlandı. Mazeret durumları için daha sıkı bir denetim sistemi getirildi. Atamalar bilgisayar ortamında kura ile yapılarak şaibeler ortadan kaldırıldı." *Türkiye Bülteni* 47 (2008): 51.

45 "Bugün 120 bin olan doktor sayısını 2015'te 130 bine 2019'da 155 bine, 2023'te 200 bine yani yaklaşık iki katına çıkaracağız. Şu anda 163 bin olan ebe hemşire sayısını 2015'te 238 bine, 2019'da 310 bine , 2023'te 400 bine çıkaracağız. Toplamda 650 bin olan sağlık sektöründe çalışan sayısını da 2015'te 715 bine, 2019'da 853 bine, 2023'te 1 milyon 100 bine ulaştıracağız." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 84, www.akparti.org.

46 "Hastane kapısına kavuşup da 'çok şükür hastaneye yetiştik kurtulduk' diyen hastaların 'yerim yok' denilerek geri gönderilmesi çok üzücüdür. Bunu yaşayanlar için de bir faciadır. Bu durum sağlık çalışanlarından kaynaklanan bir durum değil, altyapı yetersizliğidir." dedi. Akdağ, sağlık hizmetlerinin yeterli hale getirilmesi için hem kamu hizmetlerinin kullanılacağını hem de özel sağlık hizmeti veren kuruluşlardan destek alınacağını bildirdi." "Sağlık Bakanı Akdağ: İstanbul'da Acil ve Yoğun Bakım Ünitelerinin Sayısını Artıracağız," *Zaman*, January 11, 2003. http://arsiv.zaman.com.tr//2003/01/11/marmara/h2.htm.

47 "Sağlıkta Dönüşüm Programı -biraz önce de söylediğim gibi- aile hekimliğini esas alan bir sistem ve biz bu sistemi oluşturmaya doğru giderken bir taraftan da mevcut sistemin -şu anda yürüyen sistemin- rehabilite edilmesiyle uğraşıyoruz. Bunu şöyle örneklendirebiliriz: Türkiye'de yüzlerce, binlerce sağlık ocağında maalesef verimli bir hizmet verilemiyordu. Bir sağlık ocağında 8 -10 hekim varken, 1 veya 2 odada poliklinik hizmeti, hastane muayene hizmeti veriliyordu. Biz bunu hangi şekile dönüştürdük? Bir sağlık ocağında kaç tane hekim varsa, o kadar da hasta muayene odası olur. Bu şekle dönüştürdük. Hastanelerde de benzeri durum vardı. On tane uzmanın olduğu bir hastanede iki tane poliklinik açılmış durumdaydı. Mümkün olan her alanı kullanarak hastanelerimizde de poliklinik oda sayılarımızı artırıyoruz. Hekimler başta olmak üzere çalışan personelimizin verimliliğini artırarak, böylece halkımıza verilen hizmetin daha doğru bir hale gelmesi için çalışıyoruz." *Türkiye Bülteni* 5 (October 2003): 42-43.

48 "Değerli arkadaşlar, biz, slogan üreten bir parti olmaktan çok iş üreten bir parti olma gayreti içindeyiz. Birileri, geçmişte milletin hanesine bir tuğla koymuşlarsa Allah onlardan razı olsun. Ancak, bizim tek tek tuğlalarla geçirecek vaktimiz yok. Yarın, yarım bırakılanı bitirecek ve çok daha iyilerini yaparak

milletin huzuruna çıkmanın huzurunu yaşıyoruz." "Antalya Milletvekili Osman Akman'ın 14 Mart 2007 tarihli Konuşması," March 14, 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm.

49 "Değerli arkadaşlar, ülke genelinde yapmaya çalıştıklarımız ortada. Sağlık alanında yatırımların AK Parti dönemi öncesinegöre nasıl olduğunu Antalya örneğinden yola çıkarak aktarmak gerekirse; iktidarımız döneminde Antalya'da vatandaşlarımızın hizmetine Mart 2004'te Antalya Ağız Diş Sağlığı Merkezini, Nisan 2005'te 100 Yataklı Kumluca Devlet Hastanesini, Haziran 2006'da 206 Yataklı Aşır Aksu Hastanesini hizmete açtık. 100 Yataklı Serik Devlet Hastanesi inşaatını bitirdik. Yine, inşallah, bu yıl içinde haziran ayında 400+200 yataklı Antalya Devlet Hastanesini hizmete açacağız, ki, bu hastane Antalya'nın merkezine yapılan en büyük devlet yatırımlarından biridir. Yine, bu yıl içinde 100 Yataklı Kumluca Devlet Hastanesinin temelini atacağız. Alanya, Kaş, Kemer, Finike ve Elmalı ilçelerimizin devlet hastaneleri için yerlerinin tahsis işlemlerini tamamladık. İnşallah, onları da kamu-özel ortaklığı ile yapacağız. Yatak sayısı açısından nereden nereye geldiğimizi de, zamanımın yetmemesi nedeniyle aktarmaya gerek olmadığı kanaatindeyim." "Antalya Milletvekili Osman Akman'ın 14 Mart 2007 tarihli Konuşması," March 14, 2007, https://www.tbmm.gov.tr/tutanak/donem22/yil5/ozet/075.htm.

50 "Cumhuriyet tarihimizde inşa edilen toplam 10,5 milyon metrekare sağlık alanının yarısı AK Parti iktidarları döneminde gerçekleştirilmiştir. 2002 yılında 161 bin olan hasta yatağı sayısını 2010 yılında 201 bine yükselttik. Mevcut yatakların da 20 bininde koğuş sisteminden, banyosu tuvaleti içinde olan oda sistemine geçilmiş ve eski olan hastaneler bu anlayışla yeniden düzenlenmektedir. Bu kapsamda Sağlık Bakanlığının nitelikli yatak oranı yüzde 6'dan yüzde 30'a yükselmiştir. Hedefimiz 2015 yılı sonuna kadar tüm yataklarımızı nitelikli hale getirmektir." "61. Hükumet Programı" 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm.

51 "İktidarımız döneminde 554'ü hastane, 1467si birinci kademe sağlık kuruluşu olmak üzere 2021 yeni sağlık tesisi inşa ettik. Kamuya ait sağlık kuruluşlarındaki muayenhane sayısını %400 arttırarak vatandaşlarımızı muayene kuyruklarından kurtardık. 2002'de 20000 hastaya bir uzman muayenehanesi düşerken şimdi 2 bin kişiye bir uzman muayenehanesi düşüyor. 2002'de 869

olan yoğun bakım yatak sayısını 9400'e çıkardık. Hastane odalarını koğuştan gerçek hastane odasına dönüştürdük. İçinde banyosu ve tuvaleti olan oda sayısında %500'lük artış sağladık. Oluşturduğumuz 98 gezici sağlık birimiyle 18 milyon muayene yaptık." Ak Parti Tanıtım ve Medya Başkanlığı, *Alnımızın Akıyla 9.5 Yıl*, (Ankara, 2012): 68-71.

52 "Sosyal güvenlik kuruluşlarının asıl yapması gereken işlerini engelleyen sağlık işleriyle uğraşması, bu kuruluşları da verimsiz hale getirmiştir. Mevcut sağlık sistemimiz, kurumsal yapı, işleyiş, personel yapısı ve dağılımı itibariyle ihtiyaca cevap veremeyecek hale gelmiştir. Hükümetimiz, köklü değişiklikler yaparak herkesin ulaşabileceği nitelikli ve etkin çalışan bir sağlık sistemini oluşturmakta kararlıdır." "59. Hükumet Programı," 2003, https://www.tbmm.gov.tr/hukumetler/HP59.htm.

53 "Bazı Kamu Kurum ve Kuruluşlarına Ait Sağlık Birimlerinin Sağlık Bakanlığına Devredilmesine Dair 5283 sayılı Kanunun yürürlüğe girmesiyle birlikte, artan hizmet talebinin etkin bir şekilde karşılanması, tedavi sürecine ilişkin işlemlerin kolaylaştırılması ve hasta memnuniyetinin artırılması amacıyla aşağıda belirtilen tedbirlerin alınması uygun görülmüştür." "Sağlık Hizmetleri Sunumu ile İlgili Başbakanlık Genelgesi," TTB, 17 March 2005, http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=268:saik-hmetler-sunumu-e-gbaakanlik-genelges&catid=3:tebligenelge&Itemid=35.

54 "Sağlık birimlerinde ayrı bir kuyruğa yol açan, tedavi sürecini uzatan ve yasal dayanağı bulunmayan Emekli Sandığı Emeklileri, Bağ-Kur ve Sosyal Sigortalar Kurumuna tabi olanlar ile Yeşil Kart sahibi hastalardan, sağlık karnesi, sağlık cüzdanı, vizite kağıdı ve kimlik fotokopileri istenmeyecek; kontroller görevliler tarafından kayıt-kabul işlemleri sırasında hasta ile karnesinin karşılaştırılması suretiyle yapılacaktır. Bu kontrolü gereği gibi yapmadığı tespit edilen ve kamu zararına neden olan görevliler hakkında idari ve adli takibat yapılarak ortaya çıkacak kamu zararı sorumlulardan tahsil edilecektir." "Sağlık Hizmetleri Sunumu ile İlgili Başbakanlık Genelgesi," TTB, March 17, 2005, http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=268:saik-hmetler-sunumu-e-gbaakanlik-genelges&catid=3:tebligenelge&Itemid=35.

55 “Hükümetimizin kararları sağlıktan tasarruf şeklinde yorumlanıyor. Bir ülkede sağlık giderlerinin çoğu ilaçlara gidiyorsa burada bir yanlışlık var demektir. Zaten düşük olan sağlık harcamalarının çok büyük bir bölümünün ilaç giderlerine harcanıyor. Gelişmiş ülkelere göre çok düşük sağlık harcamamız var. Bu harcamalar içinde ilacın payı yüzde 40’a dayanıyorsa yanlışlık vardır. Tasarruf akılcı ilaç kullanımı ile yapılacaktır.” “Bakan Akdağ: İlaçta Tasarruf Değil, Bilinçli Kullanım İstiyoruz,” *Zaman,* April 18, 2003, http://arsiv.zaman.com.tr//2003/04/18/haberler/h9.htm.

56 “Vatandaşlarımızı hastalıktan ve yüksek tedavi maliyetlerinden korumak için kapsamlı bir Koruyucu Sağlık Stratejisini hayata geçireceğiz. Hizmet kalitesini artırmak ve maliyet-etkin sağlık hizmeti sunabilmek amacıyla inşasına başladığımız "Şehir Hastanelerini" ülkenin dört bir tarafına yaygınlaştıracağız. Evde bakım ve tele-tıp gibi uygulamalarla sağlık hizmetlerinin kalitesini artıracak, maliyetini düşüreceğiz.” “61. Hükumet Programı,” 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm.

57 “Son birkaç sene içinde aşı konusunda küçük gerilemelerin olduğunu tespit ettik. Sağlık Bakanlığı ve hükümet olarak, 2004 yılı hedefimiz, yalnızca kızamık aşısı için değil bütün çocukluk çağı aşıları için ulaşılabilecek en yüksek hedeflere ulaşmaktır. Bunun için gerekli çalışmaları yaptık.” *Türkiye Bülteni* 8 (January 2004): 47.

58 “Adalet ve Kalkınma Partisi sağlık hizmetlerini temel bir insan hakkı olarak kabul etmektedir. Hiç bir insan bu haktan mahrum bırakılamaz. Sosyal devletin görevi bu hakkın tam anlamıyla hayata geçirilmesi için gerekli tüm tedbirleri almaktır. AK Parti iktidarı bu doğrultuda son derece önemli adımlar atmış, sağlık hizmetinin en iyi şekilde verilmesini asli görev olarak görmüştür. Sağlıklı nesiller için daha kaliteli, daha adil ve daha kolay ulaşılabilir hizmet sunma yolunda hayal dahi edilemeyecek başarılar sağlamıştır.” “AKP 2007 Seçim Beyannamesi,” June 2007, 76. www.akparti.org.

59 “Önemle üzerinde durduğumuz bebek ölümlerini binde 29'dan binde 22'lere, anne ölümlerini ise yüzbinde 70'lerden yüzbinde 28'lere indirdik.2010 yılına kadar bebek ölümlerini binde yirminin, anne ölümlerini yüzbinde yirminin altlarına indireceğiz. Çocuk aşılama oranlarımızı %95'in üstüne çıkaracağız. Yalnızcagelişmiş ülkelerin aşı takvimini uygulamakla kalmayıp, aşılamadaki

son yenilik ve teknolojileri çocuklarımıza ulaştırmaya devam edeceğiz." "AKP 2007 Seçim Beyannamesi," June 2007, 78. www.akparti.org.

60 "Tam dumansız hava sahası" uygulamasını başlattığımız 2008'den bu yana 2 milyonu aşkın kişi sigarayı bıraktı. 15 yaş üzerinde sigara içen kişi sayısı 16 milyondan 14 milyona düştü. 2009'da Türkiye'de tüketilen toplam sigara sayısı 107 milyar adet iken bu rakam geçen yıl 93 milyara geriledi." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 83, www.akparti.org.

61 "Tütün, alkol, uyuşturucu ve diğer madde bağımlılıklarını azaltmak için bunlara sebep olan risk faktörleri ile mücadeleye devam edeceğiz. Halen 15 yaş üstü her 100 insanımızdan 27'si sigara içiyor. Biz bunu 2015'te %23'ün 2023'te %15'in altına indireceğiz. Bugün her 100 yetişkinin 32si obezdir. Biz sağlıklı beslenme ve düzenli fiziksel faaliyeti teşvik ederek bu oranı 2015'te 30'un, 2019'da 25'in, 2023'te is 20'nin altına indireceğiz. Obeziteyle mücadeleyi küçük yaşlarda ve okul çapında başlatacağız." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 85, www.akparti.org.

62 "Şunu da ifade etmek istiyorum: Son beş yıl içerisinde Türkiye'de ciddi bir d.nüşüm programı uyguluyoruz. Bu dönüşüm programında Hükumetimizin, Büyük Millet Meclisimizin ve sağlık çalışanlarının destekleri için, bu önemli günde, bu anlamlı günde, bütün emeği olanlara Türk halkı adına şükranlarımı ifade etmek istiyorum. Bütün bu desteklerle yürütmekte olduğumuz Sağlıkta Dönüşüm Programı'yla birçok iyileştirmelere ve yeniliklere imza attık. Bu arada, her hekime, her hekim arkadaşımıza bir oda uygulaması, teknolojik imkânları kullanma hususunda hekimlerin ve sağlık çalışanlarının yeni imkânlara kavuşturulması ve buna benzer uygulamalarla hekimlerimizin mesleki tatminleri de büyük ölçüde artırıldı." "Recep Akdağ'ın 13 Mart 2008 Tarihinde Yaptığı Konuşma," March 13, 2008, https://www.tbmm.gov.tr/tutanak/donem23/yil2/ozet/077.htm.

63 "Bizim çocuk okuldan gitti kardeşine yardımcı olmak için, römorku motora takacağına zinciri koyup kaldırıyor, taşı koyarken parmakları kopuyor. Motorla bunu kaldırıp elini çıkarıp Urfa'ya getiriyorlar. Hemen sonra Urfa'ya hastaneye geldik, Orada bizi Ankara'ya yönlendirdiler. Ondan sonra ambulans uçakla Ankara'ya gittik, ambulans uçakla baya bir rahattı. Bizimle çok ilgilendiler. Moral verdiler bize. Nerede olursan ol devlet sağlık yönünden her

yerde. Sağlıkta dönüşümü başlattık, 112 acil servislerde devrim niteliğinde yeniliklere imza attık, hayaldi gerçek oldu." "Ak Parti Sağlık Reklam Filmi" posted by anonymous user, May 16 2011, video, 0:44, https://www.youtube.com/watch?v=3qt6PQMND-I.

64 "Bizim buralarda kış cetin olur. Kar bir anda bastırır. Yollar bir gecede kapanır. Geçenlerde hanımın doğum sancıları tuttu. Hemen 112'yi aradım. Kar demedi kış demedi, kar ambulansı köye çıktı. Dediler ki şehirdeki hastaneye götüreceğiz. Öyle bir hastane yapmışlar ki her şey düşünülmüş. Çocuğum dünyaya geldi, hanımı tek kişilik bir odaya aldılar. Daha sonra da ambulansla köye kadar bıraktılar. Hemşehrim, ben zor günümde yanıma olana bakarım. Ben lafa değil icraata bakarım. Daima millet daima hizmet. Ak Parti." "Sağlık Hizmeti AK Parti Reklam Filmi," posted by anonymous user, February 24, 2015, video, 0:44, https://www.youtube.com/watch?v=EwZOEISesNw.

65 "Sağlık Bakanlığı olarak en çok önem verdiğimiz konu; önümüzdeki yılda, 2004 yılı içerisinde inşallah aile hekimliğini ülkemizde tesis etmek olacaktır. Aile hekimleri genel pratisyenlerden oluşacaktır. Bunlar şu anda pratisyen hekimlik yapan hekimler olacaktır. Vatandaşlarımız kendi özgür iradeleriyle istedikleri bir hekimi gidip seçecekler, "Siz benim aile hekimim olun, beni siz takip edin" diyecekler ve bu hekim ne kadar çok hastayı, kaydetmişe o kadar daha çok kazanacak. Kayıtlı olan hasta da düzenli bir dosyayla kaydedileceği için hem hekim hastasını daha iyi tanıyacak, hem hasta hekimine daha çok güvenecek, hem de sağlıktaki israfın da bu şekilde büyük ölçüde önüne geçmiş olacağız. Bu, hastanelerin önündeki yığılmayı da azaltacak. Aile hekimi hastasını ihtiyaç duyduğunda bir uzmana gönderecek ve o uzman da işini bitirdikten sonra dosyasına notunu koyarak yine aile hekimine geri gönderecek. Biz bunu 2004 yılı içerisinde başlatarak, bu iktidar dönemimizde de inşallah ülkede tamamen yaygın hale getireceğiz." *Türkiye Bülteni,* 5 (2003):41.

66 "Aslında Türkiye'de son 15 yıl içerisinde sağlıkta reform veya sağlıkta değişim düşünceleriyle birçok çalışma yapılmış durumda. Özellikle Rahmetli Özal döneminde başlamış çalışmalar Dünya Bankası projeleri ve kredileriyle şekillenmiş ve teorik olarak birçok değişim düşüncesi ortaya çıkmıştır. Bu çalışmaların temelinde 'aile hekimliği' kavramı vardır. Bu Türkiye'de daha önce de tartışılmış bir konuydu. Ancak iktidarların ömürlerinin kısa oluşu, koalisyon hükümetlerinin varlığı ve biraz önce söylediğim gibi hedefine tam

olarak insanı koyamamış düşüncelerin iktidar oluşu, bunun hayatiyete geçmesini zorlaştırıyordu." *Türkiye Bülteni,* 5 (2003):41.

67 "Biz, bundan böyle, 14 Mart Tıp Bayramlarında, hasta haklarının da gündeme gelmesini istiyoruz. Bu itibarla, geçtiğimiz günlerde, hasta yakınları dernekleriyle irtibata geçtik; İstanbul'u bir pilot il olarak seçtik ve İstanbul'da birkaç hastanemizde hasta haklarıyla ilgili özel bürolar oluşturduk. Bu bürolarda yalnızca kamu görevlileri değil, aynı zamanda, bu derneklerin yetkililerinin de yardımlarıyla, hasta haklarının izlenmesi için yeni bir model geliştiriyoruz. Bunu da önümüzdeki günlerde bütün Türkiye'de uygulamaya geçireceğiz." "Recep Akdağ'ın 13 Mart 2003 tarihli konuşması," March 13, 2003, https://www.tbmm.gov.tr/tutanaklar/TUTANAK/TBMM/d22/c007/tbmm22007045.pdf.

68 "Şu ana kadar bakanlığa bağlı 60 hastanede hasta hakları birimi ve hasta hakları kurulları oluşturdu. Vatandaşlar, hastanede karşılaştıkları tüm sorunları ve taleplerini bu birimlere iletebilecek. Hasta hakları birimlerine gelen şikayetler, Sağlık Bakanlığı Merkez Teşkilatı tarafından da eşzamanlı olarak sürekli izlenecek.Geçen yıl başlayan çalışmalarla birlikte, önümüzdeki yıllarda Avrupa ülkelerinde uygulanan hasta hakları kavramı Türk sağlık sistemine de yerleştirilecek. Birimlerde hastane personelinin yanında bölgede faaliyet gösteren hasta hakları derneklerinin temsilcileri de bulunacak." "Vatandaş Hakkını Ararken Cesur Olmalı." *Zaman*, May 22, 2004, http://www.zaman.com.tr/gundem_saglik-bakani-akdag-vatandas-hakkini-ararken-cesur-olmali_50843.html.

69 "Sağlık Bakanlığıma bağlı hastanelerde, hasta haklarının korunması ve hastanelerde yaşanan sorunları önlemek amacıyla kurulan hasta hakları birimlerine 2004 itibarıyla toplam 7 bin başvuru yapıldı.İnternet üzerinden ve bizzat yapılan başvuruları değerlendiren bakanlık, şikayet eden hastaların yüzde 23ünü haklı bularak, sorumlu tutulan sağlık personelinden savunma istedi.Bu personelin yüzde 20si hakkında idari soruşturma başlatıldığını belirterek, Haklarında cezai işlem başlatılan personelimiz olduğu gibi gerekli görüldüğü yerde maaş kesintisi dahi yapıldı." "Bakanlık Hasta Şikayetlerini Haklı Buldu." *Zaman,* November 30, 2004 http://www.zaman.com.tr/gundem_bakanlik-hasta-sikayetlerini-hakli-buldu_116761.html.

70 "TTB sağlık konusundaki sonuçları öngören bir yapı olarak bu konuda çok ön açıcı mücadeleye zorlayan, bu konuda olacaklar konusunda sendikaları da halkı da telaşa sürükleyen misyon taşıdı. Biraz paradoks gibi gözükebilir. O dönemin doğal bir sonucuydu, yoksulluların sağlık haklarının ellerinden alınmasına en çok tepkiyi halk örgütleri, demokratik örgütleri, işçi sendikalarından çok hekim örgütleri olaması çok uzaktan bakınca tuhaf ama türkiye özelinde bakıldığında 30 yıllık Türkiye'deki hekim meslek odası birikimi her zaman halkçı toplumcu, kamusal sağlık sisteminden yana sağlığın piyasalaştırmasına karşı bir çabası olduğu reform için ön açıcı oldu. Ama işin doğrudan muhatabı olan kitlelerin katılımları için önleri tıkalı olduğu çok açık." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author, September 2012.

71 "Ülkemizde örgütlenme eğilimi çok zayıf, TTB VE İstanbul Tabip Odası görece Türkiye örgütlülüğünün üzerinde. Meslek odaları TTB yasada tanımlanmış misyonlarını aşan bazen sendika gibi, bazen siyasi talep de iletiyor. Sağlık sendikası olmadığı için, konferderasyon ilişikine giremediği için trde TTB bu görevi yerine getiriyor. Diğer örgütsel birikime bakıldığında klasik meslek odasını aşan bir niteliği var." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author, September 2012.

72 "Yazımda dediğim gibi SES ile birlikte en büyük eylemimiz grev (görev) hizmet sektöründe olmakla birlikte bir yasal hak olmadığı için daha çok uyarı yaratma aylemi 5 kasım 2003 tarihinde yaptık. Çok hızlı bir tepki verdik. Bu programın kodlarını çözmekte zorlanmadık. Aslında bu yeni bir program değil. Yıldırım Aktuna zamanında da vardı aynı, hastanelerin özelleşmesi, aile hekimliği, gss yasa tasarısı var, bizde tartışma şu yönde oldu, sağ görüşlü tabip odaları tarafından, programın kendisine karşı çıkmayalım, biz kendi hekimlerin çıkarlarını savunalım dediler. Ama biz karşı çıktık, hekim ve halkınkini beraber savunalım dedik. Dünya örgütleirni falan da izliyoruz, Doğu Avrupa'da da benzer şekilde uygulanıyor. Ama bizim bir mücadele geleneğimiz var. bu anlamda 2003 yenilikçi oldu denebilir, kırılma oldu denebilir. Osman Öztürk (secretary general of Istanbul Medical Chamber and former member of TTB general council), tape recorded by the author, September 2012.

73 "Buna karşın sağlık hakkı talebi. Kamuyu geliştirmektense sağlık hakkını bilince dönüştürmek. Bu programı ilerlemesini durduracak bir set, geciktirildi. Acil eylem planından 3 yıllık hedeflere kadar hiçbiri öngörülen zamanda olamadı ve kısmi geri adımlar atıldı ama yürürlüğe girdi." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author, September 2012.

74 "Ben şöyle bir şey var, dünyada sağlık reformlarına karşı pandemik oldu artık. Bizimki türünden muhalefet eden yok, onlar kendilerini daha çok hekimlik alanında sınırlıyorlar, daha dar anlamda hekim çıkarları. Gencay Gürsoyla Bulgaristan'a gitmiştik 2004 yılında. Bu programı uyguluyorlardı ve tam AB öncesinde Bulgaristan Tabipler Birliği destekleyince gerginlik oldu, sosyalizm zamanında vatandaş bedavaya alıştı, şimdi para vermeye alışsın, biz hekimlerin çıkarlarını savunuruz. Zaten dünyada neoliberal politikalar uygulanıyor. International Association of Health Policy 2009 İngiltere'dekine sundum, mücadele de sundum. Tabip örgütleri açısından bizimki kadar hele de emekten yana yok. Diğerleri ile ilgili daha geniş, bazı toplumsal örgütler var. Halkların Sağlık Kongresi, Halkların Sağlık Hareketi. Sendikalar daha güçlü sağlık çalışanları için Avrupa'da. Hakikaten bilimsel dayanağı yok. Dünya Bankası patentli reforma karşı en büyük direniş bizde. Yunanistan'da da var, bizimki 9 senelik kesintisiz bir muhalefet." Osman Öztürk (secretary general of Istanbul Medical Chamber and former member of TTB general council), tape recorded by the author, September 2012.

75 "Toplumu ilgilendiren her türlü politikanın sağlık emekçisini de ziyadesiyle ilgilendirdiğine inandık. Toplum somut şeyi görmeden harekete geçmez. Dünya deneyimi örgütlülük, akademik çevre avantajından en başından itibaren öngörülüydük. Bilenler bilmeyenlere borçludur. Toplumun gündemine taşımaktı amacımız." Köksal Aydın (former chair of SES), tape recorded by the author, October 2012.

76 "Vatandaşa sorunca her gelen hükümetle sağlık bakanı ile sistem değişiyor derdi insanlar. Biz derdik insanlara sağlık sistemi değişmiyor, sadece aktörler renklerini katıyorlar. Sağlığın ticarileştirilmesinin değişmediğini söylüyorduk. Öncelikli görevimizi şöyle tanımldadık. Biz bir meslek örgütüyüz, bizden beklenen hekimlerin yararına hekimlerin çıkarını korumak. TTB 80 öncesi ve sonrasında böyle yapmayan bir örgüt. Bütün insanlar için sağlıklarını

korumak ve hastalandıklarında iyileştirmek. Dar anlamda yorumlamıyor, hekim hakkı hasta hakkı ikilemine düşmüyor. Bu reform da böyle okumaya çalıştuk. Ama bir klavuzumuz var, sağlık hakkını koruyan bir meslek sahibi insan. Piyasaya düşmüş bir meslek bunu koruyamaz. Piyasada kendini aktör olarak gören koruyamaz. Biz piyasalaşmanın hekimliği uygulamaya engel bir süreç olduğunu değerlendirdik. Hekimler çatışan değil çakışan, hekimlerden ve halkın sağlığından yana bir tutumumuz var. korumak da varolan olumsuzlukları korumak değil, kötü muayenehanecilik, kötü kamu hizmeti. Biz zaten hep 70-75-80'de de eleştirel yaklaşıyorduk. Konumumuzu ve muhalefet hattımızı, muhalefet darken bir şeye karşı olmak dar anlamında değil bir şeyin nasıl olması gerektiğini söyleyen bir hattı korumak olarak tanımlıyorduk." Eriş Bilaloğlu (former chair of the general council of TTB), tape recorded interview by the author, October 2012.

77 "Sendikamızın bütününü değil mi? şimdi sdpye gore tespitleirmiz yerindeydi ses olarak, ancak bütünlüklü bir mücadele programı koyamadık, halk ayagını olusturmada güçlük çekildiği için yasaların geri çektirilmesi için çok somut sonuç alıcı eylemler yapılamadı. Sağlık emekçilerinin mücadele programı vardı, ama bu şeye evrildi, yasa gündeme gelirse hani protestocu bir mantığa evrildi, yasa meclise gelmeden, gündeme gelmeden once işte bunun propagandasını yapıp, halka konu anlattılabilseydi belki bugün bu durumda olunmayabilirdi. Eylem programı uygulanamadı. Muhalifiz ama bunu somut eylem yapmaya dökünce sadece kadro eylemleri ile bizim şubemizin Çapa Cerrahpaşa eylemlerini tenzih ederek söylüyorum, genel anlamda muhalif olmanın ötesine gecemedi. SES en dinamik muhalefet gücü, KESK tr'deki en dinamik muhalefet örgütü sadece sosyal ve özlük haklardan ziyade tüm ülkenin politik gündemine dair de sözü olan bir sendikayız." Ersoy Adıgüzel (chair of Aksaray branch of SES), tape recorded by the author, October 2012.

78 "Sağlıkta dönüşümün iki tane mağduru var. Biri hastalar, giderek kaliteili hizmetten mahrum kalacaklar. Herkesin kafasında şu var, eskiden özelde bir şey istenince acaba gerekli miydi denirdi şimdi devlette de bu soru akıllara geliyor. Beykoz Devlet Hastanesi, Baş Hekim Genelgesi: tüm hastalar acilden geçecek. Hepsine yatış verilecek. Sistem yalnız bırakıyor ve mecburen çözüm üretiliyor. En fazla sıkıntıyı taşeronlar çekecek, ücretler düşürüldü, asgari ucrette çalışanların bile ücretleri düşürüldü. 150 lira birden düşürüldü. Bu iki kesimi

bir araya getirmeye karar verdik. 10 yılda ne yarattık? Bir farkındalık. Hiçbir zaman toplumsal hareket haline dönüşmedi. Bu şeyi gözden geçirecek ya da durduracak bir yöne bürünmedi, bir tarafta kamusal sağlığı savunan bir taraf, diğer tarafta piyasacılığı savunan bir hükûmet ve çok güçlü. Öncekiler yapamadı ama (1990 Aktuna zamanda Dünya Bankası tarafından Ulusal Sağlık Kongresi'nde önerildi ve reddedildi) Türkiye'de bunu uygulayacak irade yoktu, emekçi hareketi güçlü, kürt sorunu, islami hareket, koalisyon, o nedenle cesaret edemediler. Engelleyemedik ama farkındalık yarattık. Eylemlerde pek çoğunda hastalar bizim eylemlere destek veriyorlar. İlk yıllarda öyle değildi. Farkındalık yarattık." Tufan Sertlek (former secretary general of Dev Sağlık-İş), tape recorded by the author, July 2012.

79 "2003 öncesi mevcut tahribata uğratılan sağlık sisteminin 80'lerin ortasından 90lar boyunca ufak ufak tahribata uğratılan, altyapısız, donanımsız, finansmansız bırakılan SSK hastaneleri veyahut sağlık ocaklarının bu tahribatına karşı, ya da döner sermaye uygulamalarına karşı kamusal sağlık sisteminin bütçeden daha çok sağlığa pay ayrılması ve kamuda çalışan hekim ve sağlık çalışanlarının daha görece ücretlerle nitelikli bir sağlık hizmeti sunacakları altyapıya kavuşması yönünde mücadele vardı. Sistem yine de kamusaldı, döner sermaye ile hafiften isletmesellese de yine de kamusal bir hizmetti. Bunun niteliğinin arttırılması, çalışanların özlük haklarının arttırılmasına yönelik bir mücadeleydi. Yeni kamu hastaneleri açılmadığı gibi tamamen tüketim odaklı özel hastanelere kaydurulıyor. SGK sadece hizmet satın alan konumda." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author, September 2012.

80 "Özal'ın bile diyemediği şeyi AKP dedi, devlet sağlık hizmeti vermesin. Yüksek oya güvenerek. Üç ayağı var bu işin, sağlık alanının çevresi kuşatıldı. Ama esası duruyordu, bazı şeyler duruyor, hala, koruyucu sağlık hizmetleri vesaire vardı. 2024 sayılı yasa duruyordu, çok iyi bir yasa koruyucu sağlık hizmetlerini tanımlama açısından. 2, hastaneler hala devletin mülkiyetindeydi. Prime dayalı da olsa ücretsiz sağlık hizmeti veriliyordu. 3, SSK Emekli Sandığı ve BAĞKUR adı altında bir kamu sosyal güvenlik şemsiyesi vardı, bunları liberal sisteme entegre etmek gerekiyordu. AKP'nin esas yaptığı buydu. Bu üç alanı liberal sisteme entegre etmek AKP'nin amacı. Omurga bu üçüydü, çökertmeyi başardılar. Sorunlar bunların üzerinden ilerleyecek. Sağlık ocakları

aile hekimliğine dönüştü. Bu aslında muayenehane hekimliğidir. Devlet sadece elektrik, su, kira desteği veriyor, hekimler bir sure sonra kendi başlarının çaresine bakacaklar." Tufan Sertlek (former secretary general of Dev Sağlık-İş), tape recorded by the author, July 2012.

81 "Esastan farklı, diğerleri son 30 yıldakiler zemin hazırladı ama hiçbiri esası değiştirmedi, anlık uygulamalardı, mevzuata yönelik. Sağlıkta Dönüşüm Programı yapısal bütünlüklü ve bir dünya bankası projesi. Şu anki ileriye yönelik riskler barındırıyor. Esas itibarıyla hastayı müşteri haline getiriyor Sağlıkta Dönüşüm Programu, hekim emeğini ucuzlatıp esnek çalıştırıyor, hastaları da potansiyel müşteri olarak konumlandırıyor." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author, September 2012.

82 "AKP'nin avantajı önceki sistemin çok sorunu olması. Bir çok prosedür ortadan kalktı, SSK'lılar sadece belli hastanelere gidebiliyordu. Tüm pürüzler temizlendi, uygulanabilmek için, şu an üniversite hastaneleri de beğlanmak üzere. Şimdi sevke gerek yok, ilk zamanlar özele ödenen katkı payı azdı, devlette en çok şikayet edilen şey asık surat, konforsuzluk, özelde karşıtı vardı. Şimdi katkı payları 90'a çıktı, tekrar devlet hastanelerine yöneliniyor." Tufan Sertlek (former secretary general of Dev Sağlık-İş), tape recorded by the author, July 2012.

83 "Elma şekerleri sundu, özel hastane, ilaca kolay erişim sağlık hizmetinin piyasaya açılması diğer tüm özlelleştirme girişimleriyle birlikte bir özelleştirme girişimidr. Bir KİT gibi once piyasaya açılıp sonra uluslararsı sermayeye bir yatırım aracına dönüşmesidir. Açık açık sonuçları gözrünüyor. Bu yönelim artık kendini sonuçlarıyla gösteriyor. Piyasalaştırma, özelleştirme süreci doğal olarak sağlığı bir hak olmaktan çıkıp tüketim malzemesi haline dönüştürüyor. Parası olanın parası olduğu ladar ister pirim ister cepten ödeyerek, satın alınan hizmete dönüştürülüyor. Toplumun bunu benimsemesi için kaz gelecek yerden tavuk esirgenmemektedir. Ve burada gerek hekimlerin performans ödemelerinin arttırılması gerekse azaltılan güvencisizlerin gelirlerinin arttırılması, gerekse vatandaşların kısa dönemde ilaç harcamalarında artış, daha çok tetkik vesaire yanılsama yaratıyor. Vatandaş sanki daha iyi bir sağlık hakkına ulaşmış olduğunu düşüniyor, çok donanımlı, ideolojik ya da politik duruşu olan insanların ancak durumu anladığı bir portam oluyor.

Ciddi bir örgütlenmeye dönüşmüyor." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author , September 2012.

84 "Ben eskiden beri bir şey söylüyorum, bu medyanın etkilediği bir süreç. Sağlık bakanlığı bu reform ortaya koyarken aslında bir takım şeyleri, uygulamada olmayan şeyleri ortaya sürmesi söz konusu. Maddi tarafını destekleyerek uygulamaya yedriyor ve olumlu bir cevap alıyor. İşin özünde, aile hekimliği sistemine bakıldığında, alternatifi pratikte lafa dökmek anlamında öyle olmasa da insanlar cepten para ödüyorlar, ama ilk etapta sübvanse ediyorlar. Günün birinde kaynak bittiğinde hop ortadan kalkacak. Yoksa temel metin dediğin şeyde bir takım izahatelerin ötesinde propaganda var, ama onun 180 derece zıttı bir şey yapmış. Gerçeklikten ziyade doğruluk payı yok. Yoksa temel metin dediğin şeyde bir takım izahatelerin ötesinde propaganda var, ama onun 180 derece zıttı bir şey yapmış. Gerçeklikten ziyade doğruluk payı yok." Mustafa Sütlaş (journalist, former member of the executive board of Istanbul Medical Chamber), tape recorded by the author, July 2012.

85 "Performansa dayalı ek ödeme. 2004 Ocak'tan bu yana hasta başına para alma, bu kendi içinde bir kırılma. Hekimler cumhuriyet tarihinin en iyi paralarını kazandılar, hep böyle gidecek sandılar, esas önemli şey, tam gün önemli ama esas önemli hastaneleri işletme haline getirmek. Torba yasanın içine kamu hastane birliklerini de koydular. Yavaş yavaş uygulanıyoır. Hastanenin 7 kişilik yönetim kurulu, kapatma açma kliniklerle ilgili yetkileri olacak, üç sacayağı tamamlanıyor." Tufan Sertlek (former secretary general of Dev Sağlık-İş), tape recorded by the author, July 2012.

86 "Tabii mütevelli heyeti, bunun ticari insanlardan oluşmaları, hatta yani dünyada başka bir yerde örneği yok. Sağlık alanında bir kuruluş özelleştiği zaman, temel dayanağı sağlıkla ilgili bir faaliyette bulunma zorunluluğudur. Bizdeki taslaklarda ve yapılmaya çalışılan, vazgeçip başka şey yapma hakkı içerecek şekilde şekilleniyor. Bunun amacı başka, pazarda daha cazip olabilecek bir yapı yaratmaya çalışılıyor. Burada insanların yaptıkları ile söylemlerinin çakışmamasından doğan, kaynaklanan rahatsızlıkları, nasıl şey hale getiriyorlar, kabul edilebilir hale getiriyorlar, hem kendileri hem de çevreleri açısından. Televizyon programına çıktığı vakit, 180 derece tersini yaptığını söyleyerek prestij sağlıyor, ya da bir destekçi sağlayabiliyor." Mustafa

Sütlaş (journalist, former member of the executive board of Istanbul Medical Chamber), tape recorded by the author, July 2012.

87 "En büyük darbeyi hekimler yiyecek çünkü, taşeron işçilerden de daha fazla. Taşeron işçilerin koşulları reformal doğrudan bağlantılı değil. Hekimleri işçileştiriyor bu süreç, (eskiden çok para kazanıyorlardı) işçileştirmek için hekimlerin aşağılanması, tahakküm edilmesi şeklinde olabilirdi, tam günde dediğim gibi oldu. Aslında vatandaşa yaka silktiren şeylere müdahale ettiler. Hekimleri işçi pozisyonuna düşürdüler. Hekimler sonuçta doktor bey, hocam gibi nadide bir meslek grubu, hasta yakınlarından dayak yiyorlar, beş paralık değerleri yok muamelesi yapılıyor, bunuı işçileştirme süreci için yaptılar." Tufan Sertlek (former secretary general of Dev Sağlık-İş), tape recorded by the author, July 2012.

88 TTB ve İstanbul Tabip Odası sadece hekimlere olan etkisini değil, sağlık hakkı üzerine olan etkisini de öne çıkardı gerek genel sağlık sigortası yasal değişiklik, ki bu sağ reformunun finansmanı, gerekse birinci basamak aile hekimliği, kamu hastanelerinin işletmeleştirilmesi sürecinde tepkimizi ifade ederken bu programın müşterileştiği hastaları sağlık hakkını ortadan kaldırdığında, bu nedenle sağlık hakkı eksenli olması gerektiği onlarla ortak örgütlenen bir şey olmasına çalıştık. Çok güçlü olamadı, ama biz baştan itibaren bu kurguyla yürütütük bir dönem herkese sağlık güvenli gelecek platformu adı altında, hem işçi memur sendikaları hem de meslek odaları hem de dem kit örgütleri ve siyasi partiler, köy derneklerine kadar bağımsız aydınları da kapsayacak bir örgütlenme modeli oluşturuldu. Sağlık, sosyal güvenlik hakkı, sağlık sosyal güvenlik gelecek başlığında, önemli bir rol üstlendi ilk aşamada. 3-4 yılda 9000 gün olan pirimin 72000 güne düşürülmesi GSS'nin şimdi yürürlüğe giren maddeleri 2006'da yürülüğe sokulmayıp 2012'ye ertelenmesi gibi. Görece kazanımları da oldu ama sonuç olarak, sağlıkta dönüşüm programının akışı devam ediyor." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author , September 2012.

89 "Hak mücadelesi dediğimiz şey emek ve sermaye mücadelesi. Kim kimden yana. O ana bakıldığında bizim hatta gore bakanlığın o anlık verdiği karar birilerinin yararına, anlık. Başbakan profesörü ayağa getireceğim diyor, TTB sağlığa zararlıdır diyor. Uzun vadede görülecek, şu an insanlar erişiyor olabilirler. İki dil var biri emekten biri de sermayeden, biz emekten yanayız

ama kurabiliyor muyuz bilmiyoruz. SGK baskani Dünya Bankası'ndan ödül aldı. Yanlış cümle seçebiliriz ama biz hep emekten yanayız. Halkın sağlık hakkını korumaya çalışmalıyız. Öbür türlü müşteri ve hizmet sunumu oluruz, o zaman da toplumun kafasındaki hekimi konuşmuyor oluyoruz. Hipokrat yemini, sana her koşulda güvenmek istiyorum demek, hekim emekçi, bu bizce hekimlik olmaz. Eriş Bilaloğlu (former chair of the general council of TTB), tape recorded interview by the author, October 2012.

90 "Biz iki yıl once 2011 19-20 aralığından önce, Cerrahpaşa ve Çapa'da hastaları bilgilendirme çadırları kurduk, bu bilgilendirme çadırlarında hastalara açık mektuplar yazıp dağıttık, sdp, 663 saylı kanun hükmünde kararnameler o kararnamenin aslında ne demek olduğunu anlatan mektuplar dağıttık. Sağlık emekçileri bu konunun içinde olduğu için önceden sezebiliyor, bunu ama hastalara çok net ifade ettik. 19 ve 20'sinde 2 günlük grev yaptık. Cerrahpaşa ve Çapada 5000in üzerinde hasta ve sağlık emekçisi eylem yaptı. Türkiye'ye sıçrayan bir eylem oldu. Türkiye genelinde yapılan grev aslında buradan tetiklenmiş oldu." Ersoy Adıgüzel (chair of Aksaray branch of SES), tape recorded by the author, October 2012.

91 "Yahut emeklileri görüyorum onlar da diyorlar. İki aynı şekilde bu vatandaşımızın büyük bir kısmı gitmye başladı, nasıl oldu bu yani biz zaten bunun parasını çalışırken sağlık sigortasına işte yatırdık yani odur %5 %6 da işverenden kesilip işte %10 sağlık sigortası primi vardır, sen bunu 20-25 yıl idemişsin, ekstra ilaç aldığın için yahut, muayene olduğun için bir yani demek istediğim aslında doğrudan doğruya toplumun bireylerini bu kadar yakından ilgilendirmesine ragmen, bu olay bir şekilde büyük ölçüde sağlık örgütlerinin üzerine kaldı yani sendiklar, işçi sendikaları, kamu çalışanları sendikaları, yan, tam anlamıyla bunu sahiplenemediler. 2008 yılında Kadıköy'de TTB'nin bir şeyi oldu, bir mitingi oldu. Ben de hani gazetecilikten gelen bir kişi olarak aynı zamanda buraya katılan insanlarla böyle bir temas etmek istedim. Yani genel, benim izlenimim ve algımın dışında, birtakım değişik tipler gördüm, halktan insanlar gördüm. İşte diğerleri de halktandı ama az çok sendika üyeleri olduğu için tanıyordum. Bir kadıncağıza dedim siz niye geldiniz buraya? Dedi ki işte ben aslında kan kanseriyim dedi. Ve dedi ilaç aldım bilmemne falan dedi. Ondan sonra bir baktım emekli maaşımın şu kadar parası gitmiş dedi, yani başlangıçta işte biliyorsun bu gibi uygulamalarda işte, ilk önce, çok hastaneden

falan az bir para kesilmişti, efendim, eczane de az bir para, genel bir kısmı da emekli maaşından kesiliyor. Hatta kendi emekli maaşından değil kocasının maaşından kesildiği için falan dedi büyük bir tepki duydum falan dedi, onun için geldim dedi." Atilla Özsever (journalist specialized in social policy), tape recorded by the author, July 2012.

92 "2003 sonrası esastan bir değişiklik olduğu için, hekimlerin güvencesiz çalıştırma modeline sürüklenmesine karşı güvenceli iş talebini, gerek döner sermaye, performans, sağlık ocağı hekimlerinin mağduriyeti, iş yeri hekimlerinin mağduriyetleri,aile hekimliğinde mutlak kadro dayatması birinci basamak ve iş yeri hekimlerinin maduriyetleri iş güvencesini esas alan. Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author , September 2012.

93 "Biz hekimlerle birlikte gerçekleştirdik demin sözü edilen eylemleri. Biz TTB ile iş yapabilen bir sendikayız. Ortak eylemler yaptık. Daha once bir öğretim üyesi ve doktor kendini hastanenin sahibi olarak görürdü, tam gün yasasının çıkmasıyla işçileştiklerinin farkına vardılar, statüsünün farkı olsa da emeğiyle geçinen insanlar olduklarını anladılar. Yaptığımız eylemlerde taşeron işçisiyle öğretim üyesi yanyana yürüdü. Çıkarlar ortak, yasaların herkesi aynı etkilediğini anladılar. Türk Kamu sen ve Memur Sen Sendikalarına üye olan sağlık emekçilere Sağlıkta Dönüşüm Programı'na karşı eylemlerde bizimle oldular. Yukarda birleşme çok güç, yukarda darken farklı argümanlar etrafında bir şeyler dönüyor, aşağıda emekçiler birleşebiliyor." Ersoy Adıgüzel (chair of Aksaray branch of SES), tape recorded by the author, October 2012.

94 "Kimi reaksiyon anlarında geçmişe gore olabilen en kuvvetli tepkilerin dile geldiği 10 yıllık dönem yaşandı. Hekimlerin de dahil olduğu hattı halkın sağlık hakkı zemininde bunun dışında bir işçi, bir emekçi bir çalışan hekimlerin de haklarını koruyan bir hat olarak kurduk. Güçlü iktidar aslında anti demokratik ve örgütlenmeyi engelliyor. Bunlara ragmen bu birliktelik başarı. Ama elde edilmiş somut kazanımlar nelerdir? Hayır bir başarı yok. Emeklilik maaşı, emeklilik ilramiyesi, çalışma süresi sağlık alanında 600-700bin çalışan var çalışma yaşamının güvencesizliğinden sözedilebilir. Düne göre daha fazla bir araya gelen bir örgütlülük var. Hekimler diğer sağlık çalışanlarıyla birarada olmaya çok fazla yatkın değildirler. Birçok gerekçe var, buna rağmen bizim de TTB olarak irade koymamızla birlikte bir süreç organize edildi. Farklı

bakışları, sağ-sol bir arada örgütlemeye çalıştık ama icabet etmeyenler oldu. 13 Mart mitingi billurlaşma noktası. Tüm sağlık alanındaki kapsayıcılığı sağlamıştır. Tüm yelpazeyi kapsayabilmiştir. Büyük çoğunluğu sağlıkçı en az yarısı da hekim. Hekim olmayan sağlıkçılarla daha fazla bir arada olabilen bir iradeyi gösterebildik." Eriş Bilaloğlu (former chair of the general council of TTB), tape recorded interview by the author, October 2012.

95 "Bazıları buna başta TTB adımlar attı, bazı meslek odaları adımlar attı sendikalar için de benzer şey söylenebilir. Verebilirim isim de verebilirim. Tabip odaları açısından ana eğilim bu programı durdurmaya ya da tam karşı çıkmaya mücadele etmeye odaklanmışken bazı meslek odaları diş hekimleri gibi, eczacıların birliği gibi işin büyüklüğünü görmeden köklü sonuçları görmedeni anlık bazı adımlarından günlük avantajlar, kendi üyleri için küçük çıkarlara odaklandılar. Istanbul Eczacı Odası kendi merkezine ragmen daha kararlı ve daha net işin büyüklüğünü hissederek daha net durdu." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author , September 2012.

96 "Ancak diğer sendikaların başta KESK'e bağlı, SES olmak üzere 90'lardaki dinamizmini bu programa karşı güçlü bir biçimde dönüştüremediği çok açık. O birikimini 90'lardaki fiili sendikal çabayı halen sannki 90'lardaki bir toplu görüşme sendikacılığını memur sendikacılığını sürdürebilecekmiş gibi, özellikle programın ilk döneminde devam ettirmeye çalıştı. Bu aslında tamamen değişimiş bir programın karşısında eski program varmış gibi bir mücadeleci sendika görüntüsü yaptı, yine mücadele etti ama ne kendi örgütsel formunu, ne bakışını, önerilerini bu döneme uyarlayamadı." Ali Çerkezoğlu (member of TTB general council), tape recorded interview by the author , September 2012.

97 "SSK Sağlık kurumları hükümet tarafından bir oldu bittiye getirilerek Sağlık Bakanlığı'na devredilmek istenmektedir. Kamu Yönetimi Temel İlkeleri Kanunu Tasarısı'nda da ifade edildiği gibi Sağlık Bakanlığı'na bağlı tüm sağlık tesisleri özelleştirilmek istenmektedir. Bu kanunda Çalışma ve Sosyal Güvenlik Bakanlığı bu uygulamanın dışında bırakılmıştır. Bu devir yasası ile birlikte SSK Sağlık Kuruluşlarının da yerel yönetimlere devredilmesi imkan dahillerine girmiştir. Kısacası Hükümet yetkililerinin ifade ettiği gibi sağlık tek elde toplanmayacak, çok sayıdaki ele dağıtılacaktır. Sağlık Bakanlığının buradaki

rolü bir tür aracı kuruluştur." "Emek Platformu Sosyal Devlet Sosyal Adalet Mitingi: 20 Kasım 2004," TMMOB, last modified November 11 2004, http://www.tmmob.org.tr/icerik/emek-platformu-sosyal-devlet-sosyal-adalet-mitingi-20-kasim-2004.

98 "Hükümetin böylesi bir girişimde bulunması, hukukun çiğnenmesidir ve Anayasaya aykırıdır. Bakan devir işlemiyle sağlık hizmetlerinin merkezileştirileceğini, düzene konulacağını iddia ediyor, bu doğru değil. Oysa problem burada yatıyor. SSK hastanelerinin harcamalarının büyük bir kısmı 'hizmet alımına' gidiyor. Bu hizmet alımları da daha sonra birer soygun mekanizmasına dönüşüyoR. Emeklilik fonlarını paylaşmak, sağlık hizmetlerini satarak daha fazla kar etmek amacı güdüyorlar." "Disk: SSK Hastaneleri Devredilemez," *BIANET*, October 21, 2004, http://bianet.org/bianet/saglik/45658-disk-ssk-hastaneleri-devredilemez.

99 "Bu yasa ile tamamen işçilerin ve işverenlerin primleriyle kurulmuş olan SSK'ler hukuki olmayan bir yöntemle Sağlık Bakanlığı'na devredilmek isteniyor. SSK özerk bir kurumdur ve mal varlıkları siyasi bir kararla devredilemez. Sağlık bakanı yasa çıkmadan Valiliklere devrin altyapısının oluşturulması için genelge göndererek suç işledi. Suç duyurusunda bulunacağız. Bugün Sağlık Bakanlığı bünyesinde toplanan kamu hastaneleri yakın gelecekte yerel yönetimlere ardından da özel sektöre devredilecek. Kamu sadece sağlık hizmeti satın alır hale gelecek; sağlık hizmeti üretimi sadece özel hastaneler tarafından sağlanır hale getirilecek. Bu koşullarda, temel bir insan hakkı olan sağlık hakkı piyasada fiyatlandırılacak, yani metalaştırılacak ve herkes parası kadar sağlık hakkına sahip olacak." "İşçiler SSK Devredilirse Üretimi Durduracak," *BIANET*, January 6, 2005, http://bianet.org/bianet/emek/52180-isciler-ssk-devredilirse-uretimi-durduracak.

100 "SSK mülkleri özel hukuk statüsündedir. Şayet hükümetin sağlığın sunumunu tek elden planlama ve verme gibi bir gayreti varsa o halde özel sektör hastanelerini de Sağlık Bakanlığı'na devretmesi gerekmektedir. Kamu yönetimi temel kanun tasarısı ile Sağlık Bakanlığına bağlı bulunan hastanelerin yerel yönetimlere devri öngördüğünü hatırlatan Doğan, "Nitekim yasa tasarısının gerekçesinde devir alınacak olan SSK hastanelerinin daha sonra yerel yönetimlere devrinden bahsedilmektedir. Bu şekilde yerelde özelleştirme

uygulamasına SSK hastaneleri de dahil olacaktır" "İşçiler SSK Devredilirse Üretimi Durduracak," *BIANET*, January 6, 2005, http://bianet.org/bianet/emek/52180-isciler-ssk-devredilirse-uretimi-dur-duracak.

101 "Tüm bir ülke için SSK hastanelerinin devri bir dönüm noktasıdır. Karşımızda bir kuvvet vardır. Bunun için karşı kuvvetin ortaya çıkması gerekiyor. Birleşerek bir kuvveti meydana getirmeliyiz. Bundan sonra "Durum nedir?" sorusu saçmadır. Durum açık; SSK hastaneleri işgal ediliyor. Buna izin vermemeliyiz. SSK hastanelerinin önünde çadırlar kurmaya başlamalıyız. SSK'ları vermeyeceğiz, demeliyiz. SSK operasyonu sadece hekimleri ve işçileri değil 70 milyonu doğrudan ilgilendiriyor.SSK hastanelerinin Sağlık Bakanlığı'na devredilmesi ile prim katsayılarının yüzde 5'ten yüzde 12'lere yükseleceğine işaret eden Dr. Bakkalcı, şöyle devam etti: "Verilecek sağlık hizmeti ise şimdiki gibi olmayacak. Asgari bir sağlık hizmeti verilecek. Her türlü sağlık hizmetinden ayrıca katkı payı alınacak. Emekliler de ayrıca prim ödeyecek. İşçiler yeni sistemde ne kadar para yatırırsa o kadar sağlık hizmeti alacak. SSK operasyonu sadece hekimleri ve işçileri değil 70 milyonu doğrudan ilgilendiriyor." "Çadırlar Kurulmaya Başlanmalı," *Evrensel*, October 23, 2004, http://www.evrensel.net/haber/155552/cadirlar-kurulmaya-baslanmali.

102 "TTB genel Konsey üyesi Altan Ayvaz added that : Sağlık Bakanlığı sağlık hizmetini tek elde toplayacağını söylüyor. TTB de yıllardır bunu söylüyor. Ancak şu anda yapılmak istenen olay sahtekârlıktır, riyakârlıktır. Çünkü Kamu Yönetimi Temel Kanunu çıktığında tüm hastaneler il özel idarelerine devredilecek. Böylelikle sağlık hizmeti 81 parçaya ayrılacak. Daha sonra da bu hastaneleri özelleştirip piyasaya sunacaklar. Eğer sağlık hizmetini tek elden yürütmekte samimiyseler özel hastaneler, askeri hastaneler niçin bunun dışında kaldı? Niyetleri ile söyledikleri çakışmıyor." "Çadırlar Kurulmaya Başlanmalı," *Evrensel*, October 23, 2004, http://www.evrensel.net/haber/155552/cadirlar-kurulmaya-baslanmali.

103 "Amaç sağlık kuruluşlarını "tek çatı" altında toplamak değildir. Bazı kamu kuruluşlarıyla, özel sağlık kuruluşlarının bu "tek çatı"nın dışında bırakılması gerçek niyeti ve hedefi açıkça gösteren temel bir noktadır.Sağlık Bakanlığı'na bağlı kamu kuruluşlarından sağlanamayan hizmetlerle ilgili daha üst merkezlere sevk konusundaki kısıtlamaların varlığıyla ortaya çıkmaktadır.

Hükümet yaptığı düzenlemeyle, SSK'lileri yeterli olanağı olmayan, asıl görevi hastalara tanı koyup tedavi etmek olmayan"sağlık ocakları"na mahkum etmekte, onlar aracılığıyla, sayı ve nitelik olarak yetersizliği hükümet tarafından da kabul edilen ve ilk fırsatta özel sektöre devredilmek için planlar yapılan "kamu hastanelerine" sevkini dayatmakta, örneğin daha üst merkezlere ulaşmak yerine özel sağlık kuruluşlarından hizmet almaya yönlendirerek SSK'lilerin sağlık hizmetine tam anlamıyla ulaşma ve yararlanma hakkını önlemektedir." "SSK'nın Devri Hasta Hakkı İhlalini Arttıracak," *BIANET*, February 25, 2005, http://bianet.org/bianet/siyaset/55087-ssknin-devri-hasta-hakki-ihlalini-artiracak.

104 "Kaynaklar IMF'ye, faize değil, sağlığa ayrılsın.Hükümet önce SSK'ye olan 2 katrilyon borcunu ödesin. Patronların SSK'ye olan 4 katrilyon borcu tahsil edilsin. Tüm çalışanlar sigortalı yapılsın. SSK hastanelerine yatırım yapılsın, özelden hizmet alınmasına son verilsin. SSK yolsuzlukları önlensin, siyasi kadro atmalarına son verilsin. SSK'nin bütün çalışmaları halkın bilgisine açılsın.Yeni SSK hastaneleri açılsın. SSK gerçek sahipleri olan işçilere yada işçi temsilcileri ve çalışanları tarafından yönetilsin." "Sağlık Platformu'ndan SSK'ların Devrine Tepki," *BIANET*, January 12, 2005, http://bianet.org/bianet/saglik/52487-saglik-platformundan-ssklerin-devrine-tepki.

105 "Bu bir mülkiyet transferi düzenlemesidir. Anayasaya aykırıdır. Özel hukuk hükümlerine tabii bir kuruluşun nasıl kamuya intikal ettirileceği anayasada gösterilmiştir. Kamulaştırılmayla alırsınız. Bu fiilen el koyma. El koyma değilmiş gibi sunma çabası var. Bu gasptır. Bu vicdana aykırı, anayasaya aykırı, emeğe aykırı. Böyle önemli bir düzenlemenin gümrüktan mal kaçırıcasına bir suçluluk duygusu içinde bir telaş içinde geçiştirilmek istenmesi fevkalade yanlıştır. Mesele devlet hizmeti mükellefiyetinden kurtulmak. Bu işi önce yerel yönetimlere devretmek." "İşçinin Malı Gasp Ediliyor," *Cumhuriyet,* January 6, 2005.

106 "Türk Tabipleri Birliği (TTB) Genel Sekreteri Altan Ayaz, düzenlediği basın toplantısında, Sağlık Bakanlığı'nca 4 yılı aşkın süredir uyguladığı Sağlıkta Dönüşüm Programı'nın kamu hastanelerini kâr-zarar esasına göre çalışan işletmeler haline getirerek özelleştirmeyi amaçladığını ifade etti. 59. AKP Hükümeti döneminde bu yönde bir çok adım attığını belirten Ayaz, bu

bağlamda tek çatı altında toplanan hastaneler için hazırlanan "Kamu Hastaneleri Birlikleri Pilot Uygulama Yasa Tasarısının hastanelerin yönetim yapısının tümüyle değiştirilmesi, yönetim kurulu üyelerinin valilik, yerel yönetim, il özel idaresi, ticaret odası temsilcilerinden oluşması ve başına da bir genel sekreterin getirilmesini öngördüğünü anlattı. Birlikler halinde örgütlenecek olan kamu hastanelerinin tümüyle kendi gelirleriyle ayakta duran kurumlar olmaya zorlandığını vurgulayan Ayaz, "Çalışma ve ücretlendirme rejimi de değişiyor, kısacası kamu hastaneleri piyasaya açılmış oluyor" dedi." "Kamu Hastaneleri İşletme Haline Geldi." *BirGün,* September 11, 2007, http://www.birgun.net/haber-detay/kamu-hastaneleri-isletme-haline-geldi-35950.html.

107 "Yeni yasayla hastanelerin Yönetim Kurulunun görevleri ise şöyle açıklanıyor; hastane ve ünitelerinin kurulması, kapatılması, birleştirilmesi veya niteliğinin değiştirilmesi konusunda bakanlığa öneride bulunmak, Birlik Bütçesi, bilançosu, yıllık mali tabloları ve faaliyet raporu ile yatırım tekliflerini karar bağlamak, taşınmaz satın almak. Birliğin her türlü araç, gereç, malzeme ve taşınırları ile tapuda birlik adına kayıtlı taşınmazları üzerindeki yapı ve tesisleriyle birlikte satmak, kiraya vermek, devir ve takas işlemlerini yürütmek. Hazineye ait ve birliğin tahsisli taşınmazları üzerindeki yapı ve tesisleri ile birlikte tahsis amacı doğrultusunda işletmek, işlettirmek, kiraya vermek. Sağlık, avukatlık ve danışmanlık hizmetleri satın alınmasına karar vermek, personel planlaması yapmak ve birlik bünyesinde personel hareketleri için ilke kararları almak. Kadroların ihdas, iptal ve değiştirilmesine karar vermek." "Sağlıkta Dönüşümde Maksat Ticaret," *BirGün,* April 2, 2010, http://www.birgun.net/haber-detay/saglikta-donusumde-maksat-ticaret-51914.html.

108 "Sağlık Emekçileri Sendikası (SES) İzmir Şube Başkanı Ergun Demir açıklamasında "Sağlık ve Sosyal Hizmet Emekçileri olarak geçmişten bugüne, sağlığın esas olarak bir kamu hizmeti şeklinde tasarlanması ve yürütülmesi gerektiğini savunmaktayız. Halkın eşit, ücretsiz ve ulaşılabilir sağlık hizmeti alması, bu savunumuzun önemli bir parçasıdır. Hedefimiz, sağlık birimlerine çeşitli yakınmalarla gelen yurttaşların "müşteri" değil "hasta" bireylere koruyucu tedavi edici ve esenlendirici sağlık hizmetleri sunan birimlerin ise

"işletme" değil "kamu sağlık birimi" olarak tanımlandığı, tüm sağlık birimlerinde "önce para kazan" yerine, "önce zarar verme" ilkesinin geçerli olduğu sağlık örgütlenmesidir" şeklinde konuştu." "Sağlıkta Dönüşümde Maksat Ticaret," *BirGün,* April 2, 2010, http://www.birgun.net/haber-detay/saglikta-donusumde-maksat-ticaret-51914.html.

109 "İşte, yeni yasayla geçilecek "düzen"in ipuçları. Aslında, özel olarak açıklamaya gerek yok, çünkü her şey ortada. Ama, yine de oluşan tabloyu özetleyelim: Burası, bir sağlık kurumu değildir! Öncelikle, bir işletmedir. Öyle yatırımmatırıma para veren de bir işletme değildir, gerekirse, onu devlet isterse yapsın! Gelir arttırmak için, ek kurumlar açılabilir, ama her şeyden önce otomasyon düzenlenmesi gerekir. Öyle, tıbbi işlerin kaydına gerek yok; hangi işlem kaç para getirdi onu kaydetmek yeterli. Çünkü burası bir işletme! Maliyeti düşürmek için, malzeme ilaç vb gereksiz harcamalarını azaltmak lazım; israfa gerek yok. Fazla işçi çalıştırmayalım, zinhar fazla ücret ödemeyelim." Ata Soyer, "Kamu Hastane Birlikleri Yasası'nın Getirecekleri," *BIANET*, March 18, 2010, http://bianet.org/bianet/siyaset/120734-kamu-hastane-birlikleri-yasasi-nin-getirecekleri.

110 "SES: Hayati İlaçlar Bulunamıyor, Kaanlar Rukiyeler Ölüyor," *BirGün,* November 15, 2006. http://www.birgun.net/haber-detay/ses-hayati-ilaclar-bulunamiyor-kaanlar-rukiyeler-oluyor-29982.html.

111 "İmmunglobulin ilacının bulunamaması nedeni ile yüzlerce hastanın ölümün kıyısında olduğunu vurgulayan Demir, Son olarak da Kayseri'de 19 yaşındaki Rukiye Elmacı aynı nedenle hayatını kaybetti. IMF emrediyor, hükümet ilaç bedellerini ödemiyor. İlaç bulunamadığı için gençlerimiz ölüyor. Öksürük şurupları, grip ilaçları, vitaminler, kemik erimesi ilaçları, obezite ilaçları, röntgen ilaçları ve bazı kanser ilaçları ödeme kapsamı dışına çıkarıldı." Demir, hükümetin sağlık politikalarının büyük yıkıma neden olduğuna ve benzer politikaların uygulandığı ülkelerde 8,5 milyon kişinin öldüğüne dikkat çekti." "SES: Hayati İlaçlar Bulunamıyor, Kaanlar Rukiyeler Ölüyor," *BirGün,* November 15, 2006. http://www.birgun.net/haber-detay/ses-hayati-ilaclar-bulunamiyor-kaanlar-rukiyeler-oluyor-29982.html.

112 "Bu genelge ile çocuklarda, hamilelerde ve yaşlılarda vitamin kullanımına son verilmiştir. Kamunun ödeyeceği tek bir vitamin dahi listede yer almamaktadır.

Öte yandan obezite gibi Türkiye'de giderek yaygınlaşan bir hastalığın tedavisinde kullanılan ilaçlar da ödeme listesinden çıkarıldı. Tedavi edici ilaçların listede bulunmaması bu hastaların ileride, hipertansiyon, kalp, kolesterol, diyabet gibi son derece ciddi ve kronik rahatsızlıklara yakalanmalarına sebebiyet verecektir. Dolayısıyla bu noktada ortaya çıkacak tedavi maliyeden artacaktır." "Kronik Hastalıklara Davetiye Çıkarıyorlar," *BirGün,* July 13, 2006, http://www.birgun.net/haber-detay/kronik-hastaliklara-davetiye-cikariyorlar-27952.html.

113 "IMF dayatmalarının bir sonucu olarak siyasi iktidarca gündeme getirilen yasalar, ilaç ve dağıtım tekellerini gözeten düzenlemeler, eczacıların mesleki kazanımlarını tüketen ilaç fiyat kararnameleri, gününde yapılmayan ödemeler nedeniyle kullanılmak zorunda kalınan banka kredileri, haksız kesintiler, hesabı sorulamayan uygulamalar eczane ekonomilerini hızla tüketiyor. Yeni kamu ilaç alım protokolü tek taraflı olarak düzenleniyor ve eczacılara bir kölelik anlaşması olarak sunuluyor. Avans uygulaması, dayatılmak istenen 75 günlük alım süresi, eczanelerin çoğunluğunu zor durumda bırakacak, önemli bir bölümünü de iflasın eşiğine sürükleyecek." "Eczacılar 14 Ocak'ta Kadıköy'de Toplanıyor," *BIANET*, January 10, 2007, http://bianet.org/bianet/saglik/90075-eczacilar-14-ocakta-kadikoyde-toplaniyor.

114 "Eczacılar emeğinin karşılığını alamıyor. Burada sadece eczacıların değil tüm toplumun sağlık sorunlarına dikkat çekmek için toplandık" dedi.Kaplan, 2004'te çıkartılan ilaç fiyat kararnamesiyle birlikte eczacılara ayrılan payın azaldığını; ilaç üreticileri ve dağıtımcılar kar ederken eczacıların ve kamunun zarara uğradığını söyledi. Siyasal iktidarlarca gündeme getirilen yasalar, yalnızca ilaç sanayi ve dağıtım tekelleri gözetilerek hükümet eliyle yürürlüğe konulan düzenlemeler ve depoların satış koşullarında dayattığı katı uygulamalar sonucu eczacının tam bir ekonomik kıskaca alınmasını protesto etmek için buradayız." "Eczacılar Hükumet Politikalarına Karşı Yürüdü," *BIANET*, January 15, 2007, http://bianet.org/bianet/siyaset/90212-eczacilar-hukumet-politikalarina-karsi-yurudu.

115 "İmalatçı/ithalatçı fiyatı 100 lira olan bir ilaç, yüzde 9 depocu kârı, yüzde 25 eczacı kârı ve yüzde 8 KDV eklendiğinde 147 liraya satılıyor. SSK'nın 100 liralık imalatçı/ithalatçı fiyatı üzerinden yüzde 20 indirim sağladığı varsayılırsa

(bu oran bazı ihalelerde daha da yüksek oluyor) 100 liralık ilacın fiyatı 80 liraya düşüyor. Yeni sistemde ise KDV'li satış fiyatı olan 147 lira üzerinden yüzde 14 oranında bir indirim sağlandığında ilaç fiyatı 125 liraya, uluslararası ilaç şirketlerinin pahalı ilaçlarında indirim oranı % 7 olduğundan bu gruptaki ilaçlar için de 137 liraya düşüyor. Yani, SSK modeliyle, % 20'lik düşük iskontolu bir ihalede bile aynı ilaç 57 millyon lira daha ucuza mal edilebiliyordu. SSK'nın kamuoyuna yansıyan ilaç yolsuzluğu ihalesinde 0 (sıfır) iskonto ile 232 milyon liraya aldığı ilacı, aynı tarihte Bağ-Kur ve Emekli Sandığı 330 milyon liraya alıyordu. Bu örnek bile SSK ilaç alım modelinin ne denli avantajlı olduğunu açıkça göz önüne seriyor." "İlaçtaki Ur: Dışa Bağımlılık," Tıp Kurumu and Ankara Chamber of Commerce, last modified May 2005, http://www.tipkurumu.org/ideas.php?newsId=117.

116 "CHP Denizli Milletvekili Mehmet Neşşar, SSK'daki büyük ihale yolsuzluğuna konu olan ve her yıl yüksek tutarlarda döviz ödenen "eritropoietin" adlı ithal ilacın ODTÜ'de de üretildiğini, ancak Sağlık Bakanlığı'nın konuya duyarsız kalması nedeniyle ruhsatlandırılamadığını söyledi.Türkiye'nin yıllık 8.5 milyar dolarlık ilaç harcaması içinde payı her geçen gün artan ve gelecek yıllarda milyarlarca dolarlık dış alım yapılması beklenen "biyolojik ilaçların" ruhsatlandırılmasında herhangi bir uluslararası engel bulunmamasına karşın, Sağlık Bakanlığı'nın duyarsızlığı yüzünden bu ilaca ruhsat verilmediğini ifade eden Neşşar, eritropoietin adlı ilacın üretimi için 2-3 milyon dolarlık yatırımın yeterli olacağını kaydetti.Neşşar, "Sağlık Bakanı gerçekten değişim ve dönüşümden söz ediyorsa, çok uluslu ilaç şirketlerinin patronları yerine, ülkenin önde gelen Biyoteknoloji ve genetik bilim adamlarının tavsiyelerini dinlemekle işe başlamalıdır" dedi." "Bu sorunun Tedavisi Yok mu?" *BirGün,* May 14, 2006, http://www.birgun.net/haber-detay/bu-sorunun-tedavisi-yok-mu-26938.html.

117 "Sağlık Bakanlığı'nda denetim mekanizmasının doğru işlemediğini söyledi.Aydın, denetim mekanizmasının doğru işlemediğini belirterek, "Sağlıkta dönüşüm programı yolsuzluk programıdır. Sağlığı özel sektörü devretmek yolsuzluğun önünü açmaktır. Bir yandan IMF sağlık alanına müdahale ediyor, bir yandan da hükümet piyasa egemenlerini koruyor.

Sağlıkta yolsuzluğun önünü bunlar açıyor" dedi." "Hastane Kapalı, İlaç Pahalı," *BirGün,* June 18, 2006, http://www.birgun.net/haber-detay/hastane-kapali-ilac-pahali-27441.html.

118 "CHP Grup Başkanvekili Haluk Koç, bebek ölümleri ve Birgün'ün kolera haberini gündeme getirerek, "bu sağlık sisteminin çöküş belgesidir" yorumunu yaptı. Koç, "Ankara'da 100'e yakın kolera vakası iddiası var. Ama Sağlık Bakanı'ndan çıt yok. Sağlığı piyasalaştırmaya çalışırsanız, buna bir de 'devrim' deme aymazlığına girerseniz, bu olsa olsa karşı devrim olur" dedi. "Kolera İddiası Var Bakandan Çıt Yok," *BirGün,* August 5, 2005, http://www.birgun.net/haber-detay/kolera-iddiasi-var-bakan-dan-cit-yok-23867.html.

119 "Köksal Aydın, AKP Hükümeti Sağlık Bakanlığı'nı koruyucu sağlık hizmetlerine önem vermemekle ve vatandaşı n sağlığı ile oynamakla suçladı. Aydın, "Özelleştirme politikaları, piyasaya açılan sağlık hizmetleri bu politikaları n bir ayağı. Koruyucu sağlık hizmetleri yani birinci basamak sağlık hizmetleri bir sosyal devletin sorumluluğ udur. AKP bu görevini unutuyor. Piyasaya teslim ediyor ve vatandaşı n hasta olup teravi olabileceği bir sağlık sistemini oturtmaya çalışıyor." "Salgın Hastalık Pençesi," *BirGün,* August 26, 2005. http://www.birgun.net/haber-detay/salgin-hastalik-pencesi-24101.html.

120 "Nisan ayından bu yana yapılan su tahlillerinin salgının şehir şebeke suyundan kaynaklandığını açıkça ortaya koyduğu belirtilen açıklamada, yetkililerin sorunun kaynağının bulunması konusunda işbirliğine gitmedikleri vurgulandı. Sağlık Bakanlığı'nca yürütülen "Sağlıkta Dönüşüm Programı"nın çevre ve halk sağlığına yönelik çalışmaları ortadan kaldırdığını belirten TTB heyeti, tifo ve Hepatit B gibi hastalıkların görülmesi açısından kuluçka süresinin devam ettiğini açıkladı." "Salgın Bağıra Bağıra Gelmiş," *BirGün,* December 10, 2005. http://www.birgun.net/haber-detay/salgin-bagira-bagira-gelmis-25290.html.

121 "Aydın, sağlığı piyasalaştıran zihniyetin değişmesi gerektiğini belirtti. Aydın "Sağlık politikaları bizim için kişilerden daha önemli. Bu ülke 20 yıldır IMF'nin direktifleri ile yönetiliyor. AKP Hükümeti ve Bakan Akdağ döneminde bu çalışmalar hızlandı. Sağlıkta dönüşüm projesi bu sürecin somut sonucudur. Sağlığa bütçeden yeteri kadar pay ayrılmalıdırlar. Eğer bunları yapamayacaklarsa o koltukta oturmaya hakları yok. Ya ülkenin sorunlarına çözüm

bulsun ya da o koltuktan kalksın" dedi." "Kolera İddiası Var Bakandan Çıt Yok," *BirGün,* August 5, 2005, http://www.birgun.net/haber-detay/kolera-iddiasi-var-bakan-dan-cit-yok-23867.html.

122 "İnsanlar politik anlamda bölgesel eşitsizlik ve 'sağlıkta dönüşüm' projesinin mağduru oluyorlar."Balıkesir'de yaşanan sağlıklı sürecin aksine, Iğdır'da kuş gribine müdahale geç kalındığını ifade ederek, "hayal kırıklığına uğradık" dedi." "Iğdır'da Sağlık Bakanlığı'nın iki gün gecikmeyle açıklama yapması akıllara o süre içinde hastalığın binlerce insana bulaşması ihtimalini getiriyor. Halk sağlığı açısından son derece olumsuz bir gelişme,"Balıkesir Manyas Kuş Cenneti'nde alınan tedbirlerin aynı hızla Iğdır'da alınmadığını savunan Aydın, Van'da tıbbi müdahalenin gecikmesinde hastanelerin malzeme eksikliği çekmesinin, piyasa şartlarına dayanarak Bakanlığın bu tür ilaçların eczanelerde bulundurulmasını şart koşmamasının ve Doğu'daki sağlık personeli eksikliğinin etkili olduğunu düşünüyor.Aydın, bunu da, hükümetin "kronik siyasal hantallık, sağlıkta dönüşüm projesinin yarattığı olumsuzluk, sağlık kavramının ekonomik çıkarlardan önce gelmesi ve doğuyu her alanda olduğu gibi sağlık alanında da ikincil görme" anlayışına bağlıyor." "SES Sağlık Bakanlığı'nı Geç Kalmakla Suçluyor," *BIANET*, January 5, 2006, https://bianet.org/bianet/saglik/73079-ses-saglik-bakanligini-gec-kalmakla-sucluyor.

123 Türk Tabipleri Birliği (TTB) kuş gribi salgınının tüm sorumluluğunun AKP hükümetine ait olduğunu, Dünya Sağlık Örgütü önerisi ile hazırlanan eylem planının hiçbir aşamasının gerçekleştirilmediğini söyledi. 'WHO'nun Türkiye'de tüm önlemler alındı söylemini ise "ilginç" olarak niteleyen TTB, insan ölümleri yaşanana kadar hiçbir önlemin alınmamasını sorumsuzluk olarak nitelendirdi. Başta koruyucu hizmetler olmak üzere veteriner hizmetlerinin son dönemdeki politikalarla çökertildiğine dikkat çeken Bakkalcı, "Geçici hizmetler satın alınarak sorunlar çözülemez, bu süreç yönetilememiştir" dedi. "Tüm Önlemler Alınmadı," *BirGün,* January 19, 2006, http://www.birgun.net/haber-detay/tum-onlemler-alinmadi-25714.html.

124 "Gerçeği ve daha önemlisi, o tarihten sonra da soruna yaklaşımdaki temel zihniyetin değişmediği, esas olarak eksiklikleri kapatma telaşının baskın olduğu ortada. Dünya ve Türkiye'deki bunca birikime karşın gelecek eylem planları ve gereklerinin yerine getirilmeyip, sonuçların peşinden koşma telaşı

yurttaşlarımızın ve ülkemizin geleceği konusunda derin kaygı uyandırmaktadır." "Almadıkları Önlemi Halktan Bekliyorlar," *BirGün,* January 23, 2006, http://www.birgun.net/haber-detay/almadiklari-onlemi-halktan-bekliyorlar-25778.html.

125 "Hükümetin sağlık politikalarının halk düşmanı bir yanı var. Çünkü özelleştirme eğilimindeler. Özelleşme eğilimleri, kamusal sağlık hizmetlerini büyük ölçüde geriletti. Bunda dolaylı olarak tekellerin ve ilaç şirketlerinin de etkisi var."Tavuk ölümlerinin Doğu Anadolu'da ekim ayında başladığını yeni öğreniyoruz. Olayların kamuoyunca duyulmasıysa 4 Ocak'ta. Hâlâ kuş gribinden kaynaklanan ölümleri saklama eğilimindeler."Asla saklamamaları gerekirdi. Olay duyulur duyulmaz tüm toplumun bilgilendirilmesi, hazırlıklı olunması gerekirdi. Türkiye zaten kuşların göç yolları altında; bu bilinirken çok geç kalındı.""Bilimsel yöntem sorunu olduğunu düşündüren olaylar da var" diyor Nalçacı."Manisa'daki enstitünün masraflar nedeniyle kapatılması, Hıfzısıhha başkanının kriz sırasında hacca gitmesi, kurban bayramı zamanında ülke içinde taşınan hayvanlara dair önlem alınmaması gibi sorunlar bunlar." "Kuş Gribi Sağlığa Erişim Hakkı Sorunu," *BİANET*, January 23, 2006, https://bianet.org/bianet/saglik/73702-kus-gribi-sagliga-erisim-hakki-sorunu.

126 28.04.1971 tarihinde "Halk Sağlığı Laboratuvarı" olarak hizmete açılmıştır. Sağlık Bakanlığı'nın 27.09.1979 tarih ve 3708 sayılı emri ile Refik Saydam Hıfzıssıhha Merkezi Başkanlığı örnek alınarak İstanbul Bölge Hıfzıssıhha Enstitüsü Müdürlüğü'ne dönüştürülmüştür. Bölgesindeki 10 ilin halk sağlığı laboratuvarları, bilimsel ve teknik yönden bu enstitüye bağlanmıştır. 13.09.1993 tarih ve 6305 sayılı onayla da idari açıdan Refik Saydam Hıfzıssıhha Merkezi Bakanlığı'na bağlanmıştır. Hizmetlerini, 19 Mart 2012 tarihine kadar bu kurumsal yapıda yürütmüştür.
02.11.2011 tarih ve 28103 (Mükerrer) sayılı Resmî Gazete'de yayımlanarak yürürlüğe giren 663 sayılı "Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname" ile Refik Saydam Hıfzıssıhha Merkezi Bakanlığı, Türkiye Halk Sağlığı Kurumu'na devredilmiştir. Aynı KHK'nin 35. Maddesinin 3. bendine göre, Türkiye Halk Sağlığı Kurumu'nun taşra teşkilatı olarak Halk Sağlığı Müdürlüklerinin kurulması öngörülmüştür. Bu çerçevede Türkiye Halk Sağlığı Kurumu'nun

19.03.2012 tarih ve 2012/29 sayılı yazısı ile 81 ilin Halk Sağlığı Müdürlükleri kurulmuş ve Hıfzıssıhha Enstitüsü Müdürlüklerinin kurumsal yapısı sona ermiştir. 19.03.2012 tarihine kadar İstanbul Hıfzıssıhha Enstitüsü Müdürlüğü olarak hizmet veren kuruluş; İstanbul Halk Sağlığı Müdürlüğü'ne bağlı Halk Sağlığı Laboratuvarı olmuştur. Yine Türkiye Halk Sağlığı Kurumu'nun 10.05.2012 tarih 2012/6893 sayılı "Oluru" ile de "İstanbul 1 No'lu Halk Sağlığı Laboratuvarı" adını almış ve L1 tipi laboratuvar olarak kabul edilmiştir. Bu laboratuvarın; Kırklareli, Edirne, Tekirdağ, Kocaeli, Sakarya ve Düzce'ye hizmet vermesi planlanmıştır. "İstanbul 1 No'lu Halk Sağlığı Labaratuarı'nın Tarihçesi," İstanbul İl Sağlık Müdürlüğü, accessed March 1, 2018. http://www.istanbulhalksagligi.gov.tr/ozel-sayfa/1-nolu-halk-sagligi-laboratuvari/kurumsal-yapi/tarihce.

127 "Bir insanın aynı anda üç ayrı ilde üç önemli görevde bulunması politik kadrolaşma dışında nasıl izah edilebilir? Yaz aylarında Ankara'da yaşanan kolera salgını Hıfzısıhha Merkezi tarafından saklanmak istendi. Aynı şekilde son kuş gribi salgınında da Hıfzısıhha Merkezi iyi bir sınav veremedi.Ne yazık ki bakanlık kendisine yakın bulduğu kişileri önemli görevlere getiriyor. Bu da bilgi, uzmanlık, tecrübe isteyen konularda sağlık kuruluşlarının zamanında gerekli müdahaleleri yapmasını engelliyor" diye konuştu. Hastalık ve salgınların bu kadar sık aralıklarla görülmesinin en önemli nedeninin koruyucu sağlık hizmetlerinin ihmal edilmesi olduğunu söyleyen Aydın, raporda, Ekim ayındaki salgının ardından Sağlık Bakanlığı' nca bir komite oluşturulduğunun ifade edildiğini ancak geçen 3 ay içinde bu komitenin ne tür çalışmalar yürüttüğü hakkında kamuoyuna bilgi verilmediğini söyledi. "Tehlikenin Boyutları Ciddi," *BirGün,* January 8, 2006, http://www.birgun.net/haber-detay/tehlikenin-boyutlari-ciddi-25614.html.

128 "Bu,sağlıkta dönüşüm programının kamu hastanelerini ilgilendiren bölümünün bir parçası. Eğer kadrolu statüyü muhafaza edip, tam günü uygulayacak ve hekimlerin ekonomik durumu iyileştirilecekse tamam" diyor. "Ancak sözleşmeli statüye geçilirse bu bir tür mevsimlik işçi statüsüne geçmek anlamına geliyor. Doktorların grev ve toplu sözleşme hakkı ellerinden alınmamalı." "Tam Gün Çalışalım ama Kadrolu ve Sendikalı," *BIANET*, September 14, 2007, http://bianet.org/bianet/emek/101783-tam-gun-calisalim-ama-kadrolu-ve-sendikali.

129 "Hekimlerin bir yandan kamu hizmeti sunarken, diğer yandan sundukları bu hizmetten tam olarak soyutlanamayan özel meslekî faaliyette bulunma ayrıcalığı olarak tanımlanabilecek kısmî zamanlı çalışma düzeninin halkın sağlık hizmetine erişimini olumsuz yönde etkilediği bir gerçektir. Kısmî zamanlı olarak kamu sağlık kurumları dışında sunulan hizmetler, kamuda verilen sağlık hizmetinin yükünün paylaşılması yerine, bazen kamusal hizmete erişim aracı hâline getirebilmektedir. Kısmî zamanlı çalışma sisteminin, kamu kurumunda verimlilik azalması sonucunda hastanın bilinçli veya duruma bağlı olarak özel sektöre yönlendirilmesi sonucunu doğurduğu gerçeği, genel olarak bütün hekimlerce yapılması söz konusu olmamakla birlikte, inkâr edilemez.Hekimle hastası arasında doğrudan para ilişkisi bulunması, hastaların sağlık hizmetine erişimini zorlaştırmakta, güven ilişkisini zedeleyebilmektedir. Bu, hekimlik mesleğinin itibarı açısından da kabul edilemez bir durumdur." "Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun Tasarısı," http://www.basbakanlik.gov.tr/docs/kkgm/kanuntasarilari/tasari26052009.doc.

130 "TTB: Tam Gün Çalışmaya Değil Tam Gün Yasa Tasarısına Karşıyız," *BirGün,* May 28, 2008, http://www.birgun.net/haber-detay/ttb-tam-gun-calismaya-degil-tam-gun-yasa-taslagina-karsiyiz-40749.html. "Tıp fakültelerinin bilim üreten, eğitim veren bir kurum olduğunu bu nedenle de devlet hastanelerinden farklı bir özelliğe sahip olduğunu belirterek, devlet hastanelerinin tedavi edemediği riskli hastaların tıp fakültelerine geldiğini söyledi. böylece tp fakültelerinin eğitim, araştırma yapma imkanlarından yoksun kalacağını ve sadece hastalarına hizmet veren bir konuma dönüşeceğini dile getirdi."

131 "Tasarı yasalaşırsa, kamu hastanelerinde çalışan doktorların bir kısmı ayrılabilir. Özellikle kronik, yani süre giden hastalıkları bulunan ve takibi gereken hastalar için bu durum mağduriyete yol açacak. Doktorlar alacakları ücrete göre çalışacakları yeri seçecek fakat her halükarda kazançları azalacak. Ücret kaygısı, hastalara da daha kalitesiz hizmet vermelerine yol açacak." "Tam Gün Yasa Tasarısı Hastaları da Mağdur Eder," *BIANET*, June 2, 2009, http://bianet.org/bianet/saglik/114938-tam-gun-yasa-tasarisi-hastalari-da-magdur-eder.

132 "Kamuda çalışan doktorların büyük çoğunluğu, yüzde seksen beşi, zaten şu anda da tam gün statüsünde çalışıyorlar… O açıdan değişen bir şey yok. Part-

time çalışan yüzde on beşe gelince… O da iki çeşit. Kelimenin gerçek anlamındaki part-time (yarım zamanlı) çalışma tıp fakültelerinde uygulanıyor. Part-time'cı öğretim üyeleri sabahtan öğlene kadar çalışıyorlar hastanede… Bundan sonra bütün gün çalışacaklar. Başbakan'ın sözü o anlamda doğru da... Hekimlerin çoğunluğunun çalıştığı devlet hastanelerine gelince… Normalde bütün memurlar günde sekiz saat çalışırlar ya… Sağlıkçıların mesaisi günde dokuz saattir… Part-time çalışan doktorlar ise sadece bir saat eksik çalışırlar. Full-time'cılar mesailerini akşam beşte tamamlarken, part-time'cılar dörtte bitirir, o kadar." "Tam gün'den Kalan," *BirGün,* February 2, 2010, http://www.birgun.net/haber-detay/tam-gun-den-kalan-17438.html.

133 "Kurulan sistem bıçak parasından çok daha fazla paraların döndüğü bir sistem. Üniversite ve eğitim-araştırma hastanelerinde personel çok verimsiz kullanılıyor. Birinci veya ikinci basamak sağlık hizmeti için de vatandaş buraya yönlendiriliyor. Yanlış olan nokta bu. Bir de Bakanın kendi açıklaması var. Hastaneler yüzde otuzun üzerinde fark alamaz. Bu rakam özel hastanelerde yüzde yetmiş. Yani özel hastaneye müracaat eden bir sigortalı yüzde yetmiş fark ödemek zorunda bırakılıyor. Kısacası sistem öyle bir sistem ki dönen paraların yanında bıçak parası çok küçük kalıyor." "Doktorları Muhasebeciye Çevirecek Madde İptal Edildi," *BirGün,* July 20, 2010, http://www.birgun.net/haber-detay/osman-ozturk-doktorlari-muhasebeciye-cevirecek-madde-iptal-edildi-54088.html.

134 "Sağlık Bakanı Dr. Recep Akdağ'ın "Devlet memurlarının ikinci bir iş yapmaları yasaktır. Devlet hastanelerinde çalışan doktorların ikinci iş yapabilmelerine izin veren bir kanun vardı. Bu kanun sadece doktorlar için bir istisna getiriyordu. Biz Tam Gün Kanunu'na bir madde koyarak bu kanunu kaldırdık. Bu istisna kalkmış oldu. Anayasa Mahkemesi de bu Kanun'u kaldıran maddeyi iptal etmedi. Bu halde doktorlar hem hastanede çalışıp hem muayenehane açamazlar." yaklaşımı gerçeklerle bağdaşmamaktadır ve hukuki olarak hiçbir geçerliliği yoktur." "Sağlık Bakanı Dr. Recep Akdağ, Anayasa mahkemesi'nin Kararını Israrla Yanlış Yorumlamaktan Vazgeçmeli ve Sonucu Kabullenmelidir," TTB, last modified, July, 2010, http://www.ttb.org.tr/index.php/Ek-Haberler/haber-2106.html.

135 “Sağlık Bakanı Dr. Recep Akdağ’ın Türk Tabipleri Birliği’ne yönelik sağlık hizmetlerinin paralı olmasını savunduğu şeklindeki gerçekle hiçbir ilgisi olmayan mesnetsiz suçlamaları şiddetle kınıyoruz.Türk Tabipleri Birliği; her zaman ve açık sözlülükle herkese eşit, ücretsiz ve nitelikli sağlık hakkının ve hekimlerin emeklerinin karşılığını alabildikleri bir Tam Gün uygulamasının savunucusu olmuştur ve bu doğrultuda hazırladığı alternatif “Tam Gün Yasa Tasarısı”nı da hekimlerin ve kamuoyunun yanı sıra Sağlık Bakanlığı’nın da bilgisine sunmuştur.Sağlık Bakanı Dr. Recep Akdağ’ın, kamuda çalışıp muayenehanesi olan hekimler için ısrarla kullandığı “tuzu kuru doktorlar” ifadesi ve geçtiğimiz gün bir televizyon kanalında söylediği "Neden bir üniversite öğretim üyesi, bir anabilim dalı başkanı, hem anabilim dalı başkanı olacak hem de ’muayenehanem olacak’ der? Bunun sebebi çok açık. O ana bilim dalı başkanlığını muayenehanesi için bir şekilde kullanıyor da ondan.” şeklindeki sözleri için ise şimdilik sadece; kendisinin de politikaya girmeden önce Erzurum’da Atatürk Üniversitesi’nde öğretim üyesi iken aynı şekilde çalışıp çalışmadığını sormakla yetindiğimizi belirtiyoruz.” “Sağlık Bakanı Dr. Recep Akdağ, Anayasa mahkemesi’nin Kararını Israrla Yanlış Yorumlamaktan Vazgeçmeli ve Sonucu Kabullenmelidir,” TTB, last modified July, 2010, http://www.ttb.org.tr/index.php/Ek-Haberler/haber-2106.html.

136 'Tüm mesele ne biliyor musunuz? Kendilerinde bir takım imtiyaz olanlar, kendilerini senin benim üstümde görenler rahatsız oluyorlar. Onlara göre biz memleketi yönetemezmişiz. Onlara göre seçkinlerin, imtiyazlıların bu işi yapması lazım. Onlara göre mu memlekete Kayserili bir ustanın oğlu Cumhurbaşkanı olamazdı ama oldu, bal gibi oldu." “Akdağ: Kararı Uygulayacağız ama Muayene Çilesine Müsade Etmeyeceğiz,” *Medimagazin*, August 27, 2010, http://www.medimagazin.com.tr/ana-sayfa/tam-gun-yasasi/tr-akdag-karari-uygulayacagiz-ama-muayene-cilesine-musaade-etmeyecegiz-1-77-28664.html.

137 “Ankara Tabip Odası Genel Sekreteri Semih Tatlıcan hekimlerin bir daha böyle şiddet eylemleriyle biraraya gelmemesi gerektiğini vurguladı. Tatlıcan "Nereye gidiyoruz? gerek sağlık çalışanlarına, gerekse hekimlere düzenlenen saldırılar dehşet verici bu sorun sadece bugünün sorunu değil. Sağlığa yönelik tüm olumsuzluklar bu acı sona zemin hazırladı" dedi.” “Sağlık Sisteminin Faturası Yine Hekimlere Kesiliyor,” *BirGün,* November 16, 2005,

http://www.birgun.net/haber-detay/saglik-sisteminin-faturasi-yine-hekimlere-kesiliyor-yuzlerce-24970.html.

138 “Doktorlara yönelik bazı saldırıların "saldırıyı gururuna yediremeyen doktorların bunu içlerine atmaları nedeniyle" rapora yansımadığına işaret eden TTB Genel Sekreteri Dr. Orhan Odabaşı, şunları söyledi: "Hasta yakınları tarafından bağırılan, çağrılan, tehdit edilen, tokat atılan, kurşun sıkılan doktorlarımız var. Ancak çoğu doktor, bu saldırıları gururuna yediremediği için kimseye duyurmuyor, ondan sonra da kaderine, mesleğine küsüyor." “Doktora Şiddet Artıyor,” *BirGün,* December 4, 2005, http://www.birgun.net/haber-detay/doktora-siddet-artiyor-25192.html.

139 “TTB, özellikle sağlıkta dönüşüm programının uygulanması yla sağlık sisteminde meydana gelen aksaklıkların doktorlara fatura edildiğini, sağlık sistemini beğenmeyen hasta yakınlarının, ortada sorumlu bulamayınca tepkilerini doktorlara yönettiğini düşünüyor.” “Tıpta Utanç Rekoru: 5 Dakikada Tedavi,” *BirGün,* November 19, 2005, http://www.birgun.net/haber-detay/tipta-utanc-rekoru-5-dakikada-tedavi-25004.html.

140 "Türkiye'nin geri kalmış bölgelerinin sağlık sorunlarını samimi olarak çözmek isteyen bir hükümet öncelikle sağlığı bütün yurttaşlar için doğuştan kazanılmış bir hak olarak kabul etmeli; kamu sağlık sisteminin yaşadığı derin krizi ortadan kaldırmak için gerekli yatırımları yapmalı ve hekimler ve diğer sağlık çalışanlarının özlük haklarını hızla iyileştirmelidir.” “Hekimler Mecburi Değil Gönüllü Hizmet İstiyor,” *BIANET*, June 17, 2005, http://bianet.org/bianet/toplum/62526-hekimler-mecburi-degil-gonullu-hizmet-istiyor.

141 “Doktorlara 9-10 milyar maaş verdik, gene de Güneydoğu'ya gönderemedik" iddialarının ise tamamen gerçek dışı olduğunu savunan Çerkezoğlu, "Hükümet iki yıl önce mecburi hizmeti kaldırdıktan sonra sözleşmeli personel uygulamasını yürürlüğe koymuş ve hekimleri iş güvencesiz olarak istihdam etmeye çalışmış; hekimler de iş güvencelerinin ellerinden alınmasını kabul etmemişlerdir. Telaffuz edilen rakamlar ise hiçbir şekilde gerçekleri yansıtmamaktadır." “Hekimler Mecburi Değil Gönüllü Hizmet İstiyor,” *BIANET*, June 17, 2005, http://bianet.org/bianet/toplum/62526-hekimler-mecburi-degil-gonullu-hizmet-istiyor.

142 “Mecburi hizmet, Anayasanın 5. maddesinde devletin temel amaç ve görevleri arasında yer alan, kişinin temel hak ve hürriyetlerini, sosyal hukuk devleti ve adalet ilkeleriyle bağdaşmayacak surette sınırlayan siyasal, ekonomik ve sosyal engelleri kaldırmaya, insanın maddi ve manevi varlığının gelişmesi için gerekli şartları hazırlamak, ödevi ile bağdaşmamaktadır. Anayasanın 10. maddesinde düzenlenen eşitlik ilkesine aykırıdır. 11. maddede öngörülen ‘Anayasanın bağlayıcılığı ve üstünlüğü’ ilkesine aykırıdır. 13. maddede belirtilen sınırlama ilkelerine aykırıdır. 18. maddede belirtilen ‘zorla çalıştırma yasağına’ aykırıdır. 27. maddede düzenlenen ‘bilim ve sanat hürriyetine’ aykırıdır. 42. maddede öngörülen ‘eğitim ve öğrenim hakkı ve ödevine’ aykırıdır." “Doktordan Mecburi Hizmet Davası,” *BirGün,* August 2, 2005, http://www.birgun.net/haber-detay/doktordan-mecburi-hizmet-davasi-23834.html.

143 “Genç meslektaşlarımız bundan sonra hekimliği ‘mecburi’ bir şekilde yapacak. Biz bu formülün uygun bir formül olduğu inancında değiliz. Bu hizmet mecburi değil gönüllü yapılmalıydı. Eğer uygun önlemler alınsaydı hekimler seve seve yoksulluk bölgelerinde çalışmaya gidecekti” dedi. Gürsoy, “Yargıçlar, savcılar, öğretmenler gidiyor, hekimler neden gitmesin?” dendiğini dile getirerek, sözlerini şöyle sürdürdü: “Şu haksızlığın altını çizmek istiyorum; hekim gitmediği zaman diplomasına ambargo konuyor. İstifa edip herhangi bir şekilde başka bir yerde çalışma şansı yok. Yargıç gitmediği zaman istifa edip avukatlık yapabiliyor, öğretmen gitmediği zaman özel alanda çalışabiliyor. Biz doğuya hekim gönderme konusundaki heyecanı, isteği destekliyoruz. Ancak yolun bu olmadığı inancındayız. Çünkü zorla yapılan hekimlik, hekimsizlikten daha kötü bir şeydir.” “Mecburi Hizmete Devam,” *Medimagazin*, March 20, 2006, http://www.medimagazin.com.tr/medimagazin/tr-mecburi-hizmete-devam-676-272-2557.html.

144 “Düzce Valiliği'nce hekimlere gönderilen yazıda, hekimlerin aile hekimliğini tercih edip etmeyeceklerine 1 gün içinde karar vermeleri istendi. Hekimleri 1 gün içinde karar vermeye zorlayan uygulama geri çekilmedir. Arıkök, Düzce'de aile hekimliği uygulaması için gönüllü sağlık çalışanı bulunamadığını, sisteme başvuruda bulunmayan hekimlerin ise il dışına gönderilmekle tehdit edildiklerini savundu.Hekimlerin, sorgulamadan, tartışmadan, örgütsüz hiç bir kararı uygulamayacaklarını ifade eden Arıkök,

"Sağlık Bakanlığı'nı baskıya derhal son vermeye ve aile hekimliğini kabul etmeyen meslektaşlarımızın çalışma birimlerini değiştirmeye teşebbüs dahi etmemeye çağırıyoruz" dedi. "TTB: Aile Hekimliği Dayatması Geri Çekilsin." *BIANET*, August 24, 2005, http://bianet.org/bianet/saglik/65730-ttb-aile-hekimligi-dayatmasi-geri-cekilsin.

145 "Aile hekimliğinde sözleşme imzalayan hekimlerle çalışanların, bu konuda gönüllü olmadıklarını anladık. Hekimler, iş güvencelerinin tehlikeye girdiğini düşünüyor." "Aile Hekimliği Sağlığı Piyasalaştırıyor." *BirGün*, September 22, 2005, http://www.birgun.net/haber-detay/aile-hekimligi-sagligi-piyasalastiriyor-24384.html.

146 "Aile hekimliğini kabul etmeyen hekimler arasından yapılan atama ve geçici görevlendirmelerde konuyla ilgili yasa, yönetmelik ve Denizli ili Aile Hekimi ve Aile Sağlığı Elemanı Yerleştirme İşlemleri Yönergesi ihlal edilmiştir. Vali Dr. Hasan Canpolat'ın imzasıyla yayınlanan söz konusu yönetmeliğe rağmen atamalar ve geçici görevlendirmelerin neredeyse tamamı bu maddeye aykırı olarak yapıldı. Ayrıca Verem Savaş Dispanseri, Sağlık Müdürlüğü Talasemi Merkezi, Sağlık Müdürlüğü Diabet Merkezi gibi son derece önemli merkezler işlevsiz hale getirildi." "Denizli'de Aile Hekimliği Skandalı Büyüyor," *BirGün,* December 17, 2006, http://www.birgun.net/haber-detay/denizli-de-aile-hekimligi-skandali-buyuyor-30516.html.

147 "Sağlık ocaklarında çalışan hekimlere üç kat ücret vaat edilerek aile hekimliği yaygınlaştırılmaya çalışılıyor. Sistem tüm ülkede uygulanmaya başladığında bu ücret düşürülecektir. Aile hekimleri SGK ile bireysel ve yıllık sözleşmeler yaparak çalışmaya zorlanacaklar. İstediklerinde mevcut kadrolarına dönemeyecekler. Sağlık Ocaklarının kapatılması ile hekimleri geri dönebilecekleri kadroları da kalmayacak. Süreç içinde Aile Hekimleri, özel hastanelerin ücretli çalışanına dönüşecek." "Aile Hekimliği Toplum Sağlığına, Hekimler Uygulamaya Karşı," *BIANET*, May 28 2010, http://bianet.org/bianet/toplum/122327-aile-hekimligi-toplum-sagligina-hekimler-uygulamaya-karsi.

148 "3 bin 645 aile sağlığı biriminin 345'inin halen boş olduğunu belirtti.Boş birimlerin bulunduğu ilçeler Bağcılar, Esenler, Sultangazi gibi yoksul yurttaşlarımızın yoğun olduğu ilçelerimiz. Aile hekimliği, daha başlarken, sağlıkta mevcut eşitsizlikleri daha da derinleştimektedir." "Aile Hekimliği İstanbul'da

Ciddi Sorunlarla Başlıyor," *BIANET*, October 22, 2010, http://bianet.org/bianet/siyaset/125620-aile-hekimligi-istanbul-da-ciddi-sorunlarla-basliyor.

149 "Bir yanda, binasını kendi kiralayan, bölgesindeki diğer aile hekimi meslektaşlarından 'müşteri-hasta' çekmeye zorlanan, tüm giderlerini kendi karşılayan, kendi adına personel çalıştıran, vergisini ve sigorta priminin tümünü kendi ödeyen ve en kötüsü yıllık sözleşmelerle çalışan, bir odaya kapatılmış hekimler olduğunu belirtti." "Aile Hekimliği İstanbul'da Ciddi Sorunlarla Başlıyor," *BIANET*, October 22, 2010, http://bianet.org/bianet/siyaset/125620-aile-hekimligi-istanbul-da-ciddi-sorunlarla-basliyor.

150 "112 Acil Servisleri'nde çalışan doktor sayısının 372'den 170'e ineceğini de söyleyen oda, bunun acil servis hizmetlerinde ciddi aksamaya neden olacağı uyarısında bulundu."İstanbul genelinde sayıları zaten yeterli olmayan ve hastane acil servislerinin yükünü çeken pratisyen hekimler, aile hekimliğini seçmiş ya da başka seçenek bırakılmamış ve böylece Hastane acil servisleri boşalmıştır." "Aile Hekimliği İstanbul'da Ciddi Sorunlarla Başlıyor," *BIANET*, October 22, 2010, http://bianet.org/bianet/siyaset/125620-aile-hekimligi-istanbul-da-ciddi-sorunlarla-basliyor.

151 "Yaratılanı severiz yaradandan ötürü anlayışı ile sağlıkta insan odaklı bir hizmet sunduk. Ak Parti siyasetinin temel ilkesi olan "millet hizmetkarlık" anlayışı ile hareket ettik. Bazı merkezlere karşı değil bizzat milletimize karşı kendimizi sorumlu hissederek davrandık." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 82, www.akparti.org.

152 "Diğer taraftan köy sağlık evlerinde ebe sıkıntısı yaşanıyor. Atananlar ise köylere gitmek istemiyor. Bunu döner sermaye yoluyla ebe ve hemşirelerin ilçeden gönderilmesinin sağlanmasını isteyeceğiz." "Tunçak: Sağlık Sorununu Çözeceğiz," *Zaman*, January 17 2003.

153 "Halkımızın tümünün sağlık hizmetlerinden aynı standartta faydalandığı, yoksulların primlerinin devletimizce karşılandığı, 18 yaşın altındaki çocuklarımızın tamamının sağlık güvencesi altında olduğu "Genel Sağlık Sigortası" sistemini hayata geçirdik. Hastaneleri tek çatı altında topladık ve vatandaşlarımızın sağlık sigortalarıyla bütün sağlık kuruluşlarından hizmet

almasını sağladık." "61. Hükumet Programı," 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm.

154 "Sağlık Bakanı Recep Akdağ, 53 Avrupa ülkesi arasında doktor başına düşen hasta sayısında sondan ikinci ülke olduğumuzu söyledi. 52 Avrupa ülkesinde 100 bin kişiye 280 doktorun düştüğünü Türkiye'de ise 100 bin kişiye 140 doktorun düştüğünü dile getiren Bakan Akdağ, şöyle konuştu: "Biz bu 52 ülke içerisinde de sonuncu sıradaydık şimdi sondan ikinci sırada olduk. Bir defa bu rakamlar Türkiye'de hekim sayısının yetersiz olduğuna işaret ediyor. yıllık muayene sayısıyla kıyasladığımız zaman da bir hekimin karşısına günde 50 kişi, 60 kişi hatta 70 kişinin çıktığını görüyoruz.Takdir edilmelidir ki bu sayılar çok yüksek. Dolayısıyla hem vatandaşımız için sıkıntı oluşuyor hem de doktorlarımız için sıkıntı oluşuyor. Ülkede bu kadar gencimiz üniversite okumayı beklerken ve bu kadar da doktora ihtiyaç varken hakikaten yeterli doktor yetiştirmemek ülkenin geleceği açısından çok büyük bir yazıktır. Mutlaka doktor sayımızı artırmalıyız.Birilerinin düşündüğü, iddia ettiği, değerli meslektaşlarımızı korkuttuğu gibi Türkiye'de doktorlar hiçbir zaman işsiz falan da kalmayacaktır. Onunu için de mutlaka doktor sayımızı artırmalıyız.Önümüzdeki yıl da Türkiye'nin en önemli sağlık meselesi doktor sayısındaki eksikliktir. Bu hususta da YÖK'ü göreve davet ediyorum. Çünkü hem yetki hem sorumluluk bu noktada YÖK'tedir." "Akdağ, hekim açığı için YÖK'ü göreve çağırdı," *Zaman,* December 17, 2006, http://www.zaman.com.tr/gundem_akdag-hekim-acigi-icin-yoku-goreve-cagirdi_473338.html.

155 "Bu yıl tıp fakültesi kontenjanlarının 4500'den 6000'e çıkarılmış olması büyük gelişmedir. Türkiye bu anlayışla devam ederse 2023'te yani Cumhuriyet'in 100. yılında dünyanın sağlıkta en büyük ilk üç markasından biri olur." *Türkiye Bülteni* 56 (2010): 26.

156 "Bu Yönetmeliğin amacı; etkin, verimli, hesap verebilir, vatandaş beyanına güvenen ve şeffaf bir kamu yönetimi oluşturmak; kamu hizmetlerinin hızlı, kaliteli, basitleştirilmiş ve düşük maliyetli bir şekilde yerine getirilmesini sağlamak üzere, idarelerin uyması gereken usul ve esasları düzenlemektir." "Kamu Hizmetlerinin Sunumunda Uyulacak Usül ve Esaslara İlişkin Yönetmelik," http://www.resmigazete.gov.tr/eskiler/2009/07/20090731-1.htm.

157 "Çağdaş sağlık anlayışının temel unsurları arasında yer alan aile hekimliği uygulamasını başlattık. Geleceğe dönük olarak büyük bir adım niteliğinde olan ve halen 11 pilot ilimizde başarıyla sürdürülen bu uygulamadan 9 milyon vatandaşımız yararlanmakta." "AKP 2007 Seçim Beyannamesi," June 2007, 78. www.akparti.org.

158 "Her aile ferdinin gece-gündüz ulaşabileceği Aile Hekimliği uygulamasını başlattık. Aile Hekimliği ile tüm vatandaşlarımızın birinci basamak sağlık hizmetlerini ücretsiz almasını sağladık. 20 bin 500 Aile Hekimi ile halkımızın sağlık sorunlarını yakından takip ediyoruz." *Türkiye Bülteni* 69 (2010): 28.

159 "Sağlık hizmet sunumu ile ilgili her türlü soruların cevaplandırılması için 7 gün 24 saat hizmet veren ALO 184 SABiM iletişim Hattımız bütün vatandaşlarımızın hizmetindedir. 184 nolu telefon hattı ile ulaşılabilen SABiM iletişim Hattımız SSK'lı vatandaşlarımızın da 7 gün 24 saat hizmetinde olacak, sorularına cevap verecek ve sorunlarının çözümüne katkı sağlayacaktır." *Türkiye Bülteni* 22 (March 2005): 23.

160 "Sağlık çalışanı olmak, insana hizmet etmekle eşittir.Benim bakanlığıma ait herhangi bir kamusal kuruluşta, herhangi bir sağlık personeli, vatandaşın işini herhangi bir sebeple aksatırsa, mutlaka gereken idari soruşturmaları yaptırırız. Ne Türk halkı ne de Türk hekimlerinin büyük kısmı böyle bir şeyi kabul edemez." "Akdağ: İş Bırakacak Doktorlar Hakkında Soruşturma Açılacak." *Zaman,* October 27, 2003, http://arsiv.zaman.com.tr/2003/10/27/haberler/h9.htm.

161 "İlk amacımız uyarı eylemleriyle Türkiye'de sağlık alanında yapılan yanlışları halkla paylaşmak ve siyasi iktidarla diyalog zemini aramak. Sağlık Bakanlığı'nın bütçe payı 2004 yılında en az %5'e sonraki yıl da %10'a çıkmalı. Sağlık sosyal devletin vazgeçemeyeceği görevlerin başındadır. Hasta müşteri olarak görülmemeli, hekim temel ücreti en az 2 katına çıkarılmalı." "Tabip Odası: Bu bir uyarı Eylemi; Bakan Akdağ: Demokratik Hak." *Zaman,* November 6, 2003, http://arsiv.zaman.com.tr//2003/11/06/haberler/h10.htm.

162 "1960'lı yılların sosyalist ülkelerindeki modeli istiyorlar. O yıllardaki model zamanın devletçi yapısı içinde çok uygundu. Ama artık 2003 yılındayız, Avrupa'nın yolundayız. Dünyanın ve Avrupa'nın tersine gidemeyiz. Biz 2003 yılındayız arkadaşlarımız 1960ları yaşıyorlar." "Akdağ: İş Bırakacak Doktorlar

Hakkında Soruşturma Açılacak." *Zaman,* October 27, 2003, http://arsiv.zaman.com.tr/2003/10/27/haberler/h9.htm.

163 "Üç üyeyi Sağlık Bakanlığı, iki üyeyi il genel meclisi, bir üyeyi vali bey seçecek. Sivil toplum kuruluşları da unutulmayacak. Yedinci üye "ticaret ve sanayi odası veya bunların ayrı kurulmuş olması halinde ticaret odası" tarafından belirlenecek. Üniversiteler, meslek kuruluşları, sendikalar, meslek dernekleri filan. Olur da "Biz de sivil toplumuz… Söz, yetki, karar hakkı isteriz" filan derlerse, "Oy hakkı olmaksızın" toplantılara davet edilip gönülleri alınacak." "Kamu Hastane Birlikleri Yasa Tasarısına Dair," İstanbul Tabip Odası, 25 August 2010, http://istabip.org.tr/1376-kamu-hastane-brlkler-yasa-tasarisina-dar-.html.

164 "Kolera Salgını Örtbas mı Ediliyor?" *BirGün,* August 24, 2005, http://www.birgun.net/haber-detay/kolera-salgini-ortbas-mi-ediliyor-24073.html. "Sayının sınırlı kalması büyük şans. Bakan öncelikle bu iddialar hakkında bilgi vermeli ve halkı aydınlatmalıdır. Duruma hakimiyet konusunda bir sorun var. Bu sorun Doğubayazıt'ta da karşımıza çıkıyor."

165 "Türkiye'deki Kuş Gribi Virüsü Ölümcül," BIANET, October 13, 2005. https://bianet.org/bianet/saglik/68685-turkiyedeki-kus-gribi-virusu-olumcul. "İlk etapta 8 kişi için koruyucu tedavi uygulandı. Manyas'taki kuş gribi vakasında hızlı ve duyarlı bir şekilde müdahale edildi. Korunma ve tedavide kullanılacak ilaç stokumuz yeterlidir. Panik ve telaşa gerek yoktur."

166 "Kuş Gribi AB Gündeminde, Bakan Unutalım Diyor," BIANET, October 18, 2005, https://bianet.org/bianet/saglik/68964-kus-gribi-ab-gundeminde-bakan-unutalim-diyor. "Gündemde olmayan bir konunun konuşulduğunu" savunarak, "İleride acaba yeniden olur mu? Bütün dünya ülkelerinde olabilir, Türkiye'de de olabilir. Olursa yine şimdiki tedbirler alınır. Şu anda gündemimizden artık bunu çıkarmamız lazım."

167 "AKP Kuş Gribinden Beter." *BirGün,* January 8, 2006. http://www.birgun.net/haber-detay/akp-kus-gribinden-beter-25617.html "Halkımızın başındaki asıl felaket kuş gribi değil, AKP'nin övünerek savunduğu tüccar siyasetidir" dedi. Aydın, bölgedeki yetersiz olan hastanelerin kuş gribi vakası karşısında çaresiz kaldığını belirterek hükümetin istifa etmesini istedi.

168 "Doktorları Muhasebeciye Çevirecek Madde İptal Edildi." *BirGün,* 20 July 2010. http://www.birgun.net/haber-detay/osman-ozturk-doktorlari-muhasebeciye-cevirecek-madde-iptal-edildi-54088.html. "Ücretlerin dörtte üçü performansa bağlıydı. Kamuda böyle bir anlayış olamaz. Özellikle üniversitelerde profesörlerin görevi araştırma yapmak ve öğrenci yetiştirmektir. Bu ücretlendirilmiyordu. Deniyordu ki sen baktığın hasta sayısına göre para alacaksın."

169 "Tam Günde Gerekeni Yaparız," NTV, 19 July 2010, http://www.ntv.com.tr/saglik/ttb-tam-gunde-gerekeni-yapariz,XJxMj5nTtkGrLpr8pji22Q. "Tam Gün Kanunu ile İlgili Basın Açıklaması"nda; "Anayasa Mahkemesinin kararına ve kanuna göre öğretim üyeleri dışında kamuda çalışan tüm doktorların muayenehane açması veya özel sağlık kuruluşlarında çalışması mümkün bulunmamaktadır. Bu uygulama 30 Temmuz 2010 tarihinden itibaren başlayacaktır"

170 "Doktorlar: Hedef Tahtası Olmak İstemiyoruz," BIANET, 15 November 2005, http://bianet.org/bianet/emek/70210-doktorlar-hedef-tahtasi-olmak-istemiyoruz. "Ne yazık ki, bu ne ilk, ne son örnek. Uzun yıllardan beri sağlıkla ilgili sorunların hedefi olarak gösterilen hekimler, şiddetin de hedefi oldu. Acil birimlerde, genç hekimlerin yaşadıkları ortam bir can pazarıdır."

171 Şimdi bütün sağlık çalışanları için bu sözleşmeli pozisyonlarında zaten çok daha iyi kazanma imkanı var. Memuriyet pozisyonlarında da maaşlarında artış söz konusu olduğu zaman bunun maliye politikasıyla ilgisi olduğu açıktır. Ancak biz döner sermayelerden verdiğimiz katkı paylarını artırmak yoluyla sağlık çalışanlarına ve hekimlere daha iyi bir ücret vermeyi planlıyoruz. Bizim 209 sayılı Döner Sermaye Kanunumuz var. Bu Döner Sermaye Kanunu değişiklik tasarısını şu anda hazırlamış durumdayız. Meclis'İn yeni yasama döneminde bunu da Meclis'ten geçirerek döner sermaye paylaşımında hem hekimlere hem diğer sağlık çalışanlarına çok daha iyi imkanlar inşallah sunacağız. Ama orada da bir prensibimiz var. Kimin performansı daha yüksekse, kim hastasını daha çok memnun ediyor ve dolayısıyla daha çok hasta celp ediyorsa, kim daha çok muayene yapıyorsa, müdahalede bulunuyorsa, ameliyat yapıyorsa, hasta takip ediyorsa o kişi döner sermayeden daha fazla katkı payı alacak. *Türkiye Bülteni,* no.5 (October 2003), 43-44.

172 Bu süre içerisinde, sağlık çalışanlarımızın özellikle kazançlarını ilgilendiren, çalışma şartlarını ilgilendiren birçok değişiklik gerçekleştirdik. Bunlardan en önemlisi, sağlık çalışanlarımıza ve hekimlerimize -bir anlamda, sağlık çalışanlarının ekip başkanı olan hekimlerimize- ödemeye başladığımız performansa dayalı katkı paylarıdır. Şöyle bir sistem oluşturduk: Hekimlerimiz ve diğer sağlık çalışanlarımız, kendi çalıştıkları kuruluşlarda, sağlıkocaklarında, dispanserlerde, ana-çocuk sağlığı merkezlerinde ve hastanelerde ne kadar verimli bir çalışma ortaya koymuşlarsa -gerek koruyucu sağlık hizmetleri açısından gerek tedavi edici sağlık hizmetleri açısından- gelirlerine o kadar yansıyan bir sistemle karşı karşıya gelmiş oldular. Hem kişisel performans hem de kurumsal performans, hekimlerimizin ve diğer sağlık çalışanlarımızın gelirlerini artırmış oldu. Hakikaten, bununla ciddî bir verimlilik elde edebildik. Hastanelerimizde ve diğer sağlık kuruluşlarımızda muayene ettiğimiz hasta sayıları arttı ki, fiziksel imkânlarımız söz konusu edildiğinde, hakikaten buna büyük bir ihtiyaç da vardı. Müdahalede bulunulan, ameliyat yapılan, takip edilen hasta sayıları süratle arttı. Bazı örnekler vermek isterim. Örneğin, Ankara'da, bir eğitim hastanesi olan Ankara Hastanesinde, göreve başladığımızda, polikliniklerde günde yaklaşık 3 500 kişi muayene edilmekteydi ve bu hastanede yalnızca 40 poliklinik odası mevcuttu. Bugün, ilgili hastanemizin polikliniklerinde günde 5 000 kişi muayene olabilmektedir ve poliklinik sayımız ise 120'dir. Bunun, hem hekimler açısından, sağlık çalışanları açısından hem de hastalar açısından ciddî katkıları, ciddî faydaları var. Bir defa, demin bahsettiğim rakamlardan yola çıkarsak, bir hekim, polikliniklerde günde yaklaşık 80 kişiyi muayene etmek zorunda kalıyordu; bugün, hasta sayısı artmış olmasına rağmen, 40 kişiyle günü bitirebiliyor. Dolayısıyla, bir defa, hekimlik pratiğini daha sağlıklı bir biçimde ve daha rahat bir biçimde yapma imkânına kavuşmuş oldu. Hastalar için, zaten, durum çok açık, bir hastaya poliklinikte ayrılan süre, böylece iki misline çıkmış oldu. Bunu, bütün Türkiye'de bu şekilde geliştirmeye çalışıyoruz. Bir taraftan sağlık çalışanlarımız ve hekimlerimiz için ortam daha iyi bir hale gelmiş oluyor, diğer taraftan da hastalarımız hekimlerle daha fazla yüzyüze kalma imkânını buluyorlar. "Recep Akdağ'ın 15 Mart 2005 tarihli Konuşması" https://www.tbmm.gov.tr/tutanak/donem22/yil3/bas/b070m.htm.

173 MADDE 3 – (1) Kamu hizmetlerinin, başvuru yapılan ilk kademeden sunulması ve sonuçlandırılması, başvuru mercii ile karar/onay mercii arasında birden fazla kademe oluşturulmaması esastır. MADDE 4 – (1) Basılı ortamdaki bilgi ve belgelerin elektronik ortama taşınması ve veritabanlarının diğer idarelerle paylaşılması esastır. MADDE 5 – (1) Kanunî sınırlamalar saklı kalmak kaydıyla idare, sunduğu hizmetlere ilişkin bilgileri ve mevzuatı, basılı ya da elektronik ortamda duyurur. MADDE 6 – (1) İdareler, ek-2'de yer alan örneğe göre hizmet standartlarını oluşturur. Ek-3'te belirtilen açıklamalara göre oluşturulan hizmet standartları tablosunda; hizmetin adı, başvuruda istenen belgeler, hizmetin ne kadar sürede tamamlanacağı ve şikâyet mercilerine ilişkin bilgiler yer alır. MADDE 7 – (1) İdare, sunduğu kamu hizmetlerinin özürlüler tarafından kolayca erişilebilir olması için gerekli tedbirleri alır. MADDE 8 – (1) İdare, hizmetleri yerine getirirken başvuru sahibinden istediği bilgi ve belgelerle ilgili düzenlemelerinde aşağıdaki ölçütleri esas alır. MADDE 9 – (1) İdare, gerçeğe aykırı belge verenler ya da beyanda bulunanlar hakkında yasal işlem yapılacağı hususunda başvuru sahiplerinin bilgilendirilmesi için gerekli tedbirleri alır. MADDE 10 – (1) Başvuruları esnasında, ödemek zorunda oldukları malî yükümlülükler, mevzuat dayanakları ile birlikte başvuru sahiplerine açıkça belirtilir. "Kamu Hizmetlerinin Sunumunda Uyulacak Usül ve Esaslara İlişkin Yönetmelik," http://www.sgb.saglik.gov.tr/content/files/genelgeler/2011/genelge_2011_37.pdf.

174 Bu birleşme ile SSK'lı vatandaşlarımızın sağlık hizmetlerinden yararlanmalarında bürokratik işlemleri artmamaktadır. Aksine SSK'lılarımız için yeni kolaylıklar sağlanmakta ve sağlık hizmetlerinden yararlanmada bütün vatandaşlarımız ortak bir düzlemde buluşmaktadır. SSK emeklisi vatandaşlarımız sağlık karneleri ile, fiilen çalışan SSK'lılar ise çalıştıkları kurumlardan vizite kağıdı alarak Sağlık Bakanlığı'na bağlı herhangi bir sağlık birimine (bütün sağlık ocakları ve bütün hastanelere) doğrudan müracaat edebilecek ve hak ettikleri sağlık hizmetini alabileceklerdir. Acil hallerde vizite kağıdı aranmayacak, bilahare bu işlem tamamlanacaktır. Yine SSK emeklileri ve fiilen çalışan SSK'lılar Sağlık Bakanlığı Hastaneleri tarafından Üniversite

Hastanelerine sevk edildiklerinde bu kuruluşlara Sosyal Sigortalar Kurumu'ndan ayrıca sevk almaksızın doğrudan gidebilecek ve hizmet alabileceklerdir." *Türkiye Bülteni,* no.22 (March 2005), 22.

175 Sağlıkta yönetim ve denetim mutlaka tek elde, yani Sağlık Bakanlığında toplanmalıdır. Sağlık harcamaları disiplinize edilmeli, hizmet ve ürünlerin standardizasyon çalışmaları yapılmalıdır. Bu sayede önlenecek kayıp ve kaçaklar yine sistem içinde değerlendirmeli ve özellikle sağlık çalışanlarının özlük hakları mutlaka iyileştirilmelidir. "Turhan Çömez'in 13 Mart 2003 Tarihli Konuşması" 13 March 2003, https://www.tbmm.gov.tr/tutanak/donem22/yil1/ozet/045.htm.

176 Sağlık bakanlığı olarak en çok önem verdiğimiz konu aile hekimliği. Kayıtlı olan hasta düzenli bir dosyayla kaydedileceği için hem doktor hastasını daha iyi tanıyacak hem de sağlıkta israfın önüne geçmiş olacağız. *Türkiye Bülteni* 5: (October 2003), 41.

177 "'Devletin imkanları özel sektöre aktarılıyor.' gibi yorumlayanlar var. Halbuki tam tersi, özel sektörün imkanlarından halkın yararlanmasını sağlamışız." *Türkiye Bülteni* 5: (October 2003), 45.

178 Kamu maliyesinin yükünü hafifletmek üzere Maliye Bakanlığı'nın başkanlığında Geri Ödeme Komisyonu oluşturuldu ve "Tek Geri Ödeme Sistemi" imkanı sağlandı. Geri ödeme kurumlarının ortak kararı ile en ucuz eşdeğer ilacın yüzde 22 fazlasına kadar olan ürünlerin ödenmesi kuralı getirildi. Bu uygulama ile sepetin dışında kalan bazı ilaçların firmaları, kamunun ödeme kapsamına girebilmek için fiyatlarını gönüllü olarak bir kere daha düşürdü. Bu uygulamalarla kamu maliyesi için yıllık yaklaşık 2 milyar YTL tasarruf sağlandı. *Türkiye Bülteni 47*: (April 2007), 51.

179 Mevcut yatakların da 20 bininde koğuş sisteminden, banyosu tuvaleti içinde olan oda sistemine geçilmiş ve eski olan hastaneler bu anlayışla yeniden düzenlenmektedir. Bu kapsamda, Sağlık Bakanlığının nitelikli yatak oranı yüzde 6'dan yüzde 30'a yükselmiştir. Hedefimiz 2015 yılı sonuna kadar tüm yataklarımızı nitelikli hale getirmektir. "61. Hükumet Programı" 2011, https://www.tbmm.gov.tr/hukumetler/HP61.htm.

180 "Beş yıldızlı otel konforunda hastaneler inşa ettik, ediyoruz. En son teknoloji ürünü olan donanımla sağlık kuruluşlarımızı donatıyoruz. Hasatenelrde koğuş sisteminden, banyosu tuvaleti içinde olan oda sistemine geçtik. 80 yıl

sonunda kamu hastanelerinde odasında banyo olan 7 bin yatak varken, 8 yılda 80 yıllık bu rakamı 4 kat artırdık ve 30bine ulaştık." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 82, www.akparti.org.

181 Mevcut 463 acil yardım istasyonu sayısı 26 adet daha artırılarak 489'a çıkarılmış, 613 olan ambulans sayısı, 336 adet daha alınarak 949'a çıkarılmıştır. Acil yardım hizmetlerinde çalışan hekimlerin "Acil Hekimliği" sertifika programına başlanmış, ambulans hizmetlerinin kullanılmasında yerel imkanlar devreye sokularak, ilk olarak Üstanbul Büyükşehir Belediyesi bünyesindeki ambulanslar 112 Acil Hizmetleri ile entegre hale getirilmiştir. Türkiye Cumhuriyeti Sağlık Bakanlığı, *Sağlık 2003,* (Ankara, 2004), 9.

182 "Ambulans sayımız 2002 yılında 618 idi. Bunu 8.5 yılda 4 kat artırdık ve 2547'ye yükselttik. İktidarimizdan önce vatandaş ambulansla hastasini naklettirirken para öderdi. Köylerimiz için ambulans hizmeti yoktu. Şimdi köylerimize kadar, jhatta gereketiğinde 20 hava ambulansından biri ile tamamen ücrestiz olarak ulaşan ambulans hizmeti veriyoruz. 2002 yılında 350 bin kişiden ambulansla taşınmışken 2010 yılında 2 milyon 100 bin kişiyi taşıdık, yani taşıdığımız hasta/yaralı sayısı 6 kat arttı." "AKP 12 Haziran 2011 Genel Seçimleri Seçim Beyannamesi," 2011, 84, www.akparti.org.

183 Akdağ, gazetecilere yaptığı açıklamada, hasta ile hekim arasındaki para ilişkisini önemli bir problem olarak gördüklerini, bunun sonlandırılması için kararlı olduklarını söyledi. Vatandaşların bunu kendilerinin de fark etmesi ve bu konuda bilinçlenmeleri gerektiğini ifade eden Akdağ, ''Kendilerinden maddi bir talepte bulunulduğunda, bunu karşılamak zorunda değiller. Vatandaşlarımız böyle bir meseleyle karşılaştıklarında hastane başhekimlerine, sağlık müdürlüklerine, valiliklere veya bizzat bakanlığa müracaat etsinler." dedi. "Bıçak parası'na 444'lü hat geliyor," *Zaman,* May 24, 2003, http://arsiv.zaman.com.tr//2003/05/24/haberler/h13.htm.

184 "Eleştirilerde bulunurken önceki durumlarla kıyas yapmak lazım. Yürüyüşte açılan Che Guevera pankartının sağlık sistemiyle bir ilgisi olamaz. Tabip Odalarının yanlarına çeşitli marjinal grupları da alarak, geçmişte sistem için böyle bir yürüyüş yaptıklarını ben bilmiyorum, hatırlamıyorum. Ben Türkiye'de vatandaşın bundan 8-10 sene önce çektiği sıkıntılara karşı hangi yürüyüş yapıldı çok merak ediyorum. Çünkü Tabipler Birliğinin öteden beri ideolojik görüşü var. Onların ideolojik görüşüne 'sabitliklerdinden' ötürü

katılmıyorum." "Vatandaşın Çektiği Sıkıntılar için Hangi Eylemi Yapmışlar?" *Yeni Şafak,* March 15, 2011.

185 "Kaynaklarımız kısıtlı olduğu için yeni binalar yapmak yerine atıl durumdaki sağlık kurumlarını aktif hale getirip vatandaşın hizmetine sunuyoruz. Genel Sağlık Sigortası sistemine geçildiğinde vatandaşlar özel, üniversite veya kamu hastaneleri ayrımı yapmaksızın istedikleri hastaneden sağlık hizmeti alabilecek. SSK'lı hastalara ikinci sınıf vatandaş muamelesi yapanlar hakkında cezai müeyyide uygulanacak." "Başesgioğlu: SSK'lıya ikinci sınıf muameleye ceza uygulanacak." *Zaman,* March 16, 2004. http://www.zaman.com.tr/gundem_basesgioglu-ssklilara-ikinci-sinif-muameleye-ceza-uygulanacak_26966.html.

186 "Biz bir türlü duygusal bir sendikal mücadele yaptık ve 65 yılında da o dernek bazında Türkiye çapında ilk kurumsal hekim sendikasını kurduk. Ve kurduğumuzdan üç ay sonra da tüm Türkiye'de örgütlendik. Fakat sendikada ne yaptık? Sendikada grev yok, toplu sözleşme yok. Fakat sendika adı SSK içinde ilginç bir prestije sahip, işçi sendikalarından dolayı…" Ata Soyer "Türk Tabipler Birliği- Kamu Sağlık Çalışanları Sendikaları İlişkisinin Gelişimi" in *Bir Muhalefet odağı olarak Tabip Odaları Bir Eylem Biçimi olarak Beyaz Eylemler*, ed. Ata Soyer (İstanbul:Sorun Yayınları,2005), 370.

187 "TTB'nin her türlü ideolojik saplantıdan arınmış, yasalara ve temel etik normlara bağlı kalarak ve ülkenin birliği ve bölünmez bütünlüğü ilkesinden taviz vermeden hekim sorun-ları ile ilgilenmesi gerektiğine ve hekimlerin haklarının ancak etkin diyalogla korunup iyileştirilebileceğine inanıyoruz." "Türkiye Hekim Platformu: Özlük Haklarındaki Düzen-lemeyle ilgili Çalışmalarımız Devam edecek," Medimagazin, 29 June 2009, http://www.medimagazin.com.tr/hekim/meslek-org/tr-turkiye-hekim-platformu-ozluk-haklarindaki-duzenlemeyle-ilgili-calismalarimiz-devam-edecek-2-14-20866.html.

188 "Ülkemizde 20. Yüzyıl boyunca sağlık alanında merkezi idare işdareler arasında işbölümüne bakıldığında, sağlık hizmetlerinin önemli ölçüde merkezileştiği görülmektedir. 20. Yüzyıl'ın ilk yarısında birçok hastane mahalli idareler tarafından işletilmekte iken, aynı yüzyılın ikinci yarısında hizmet sunumunun merkezde toplandığı bilinmektedir. Aşırı büyüyen ve merkezileşen sağlık hizmetleri sunumu ile ilgili iş ve işlemler, bakanlığın asli

görevlerinide yoğunlaşmasının önünde bir engel oluşturmaktadır. Sağlık Bakanlığı merkez teşkilatını esasında mahallince yürütülmesi gereken hizmetlerin yükünden kurtaracak altyapı çalışmaları Sağlıkta Dönüşüm Programı çerçevesinde büyük ölçüde tamamlanmıştır. Çeşitli kamu idareleri altında faaliyet gösteren hastaneler tek çatı altında toplanarak kamu kaynaklarının verimsiz kullanımı engellenmiştir. Sağlık personeli yetersizliği ve dengesiz dağılım sorununa mğdahale edilerek, personelin objektif esaslara ve ihtiyaçlara göre atama ve nakil sistemine tabi tutulması gibi izlenen personel politikaları sonucu personel dağılımındaki dengesizlik makul ölçülere indirilmiş, yurdun en ücra köşelerinde dahi sağlık çalışanı istihdamı sağlanmıştır. Aile Hekimliği ve Toplum Sağlığı Merkezi uygulamalarına başlanılması ile birinci basamak sağlık hizmetleri ve koruyucu hekimlik önemli ölçüde güçlendirilmiştir. Sağlıkta Dönüşüm Programı çerçevesinde atılan bu ve benzeri adımlardan sonra, hastane hizmetleri sunumunda karar verme, gelir elde etme ve harcama yapma yetki ve sorumluluklarının idari ve mali açıdan özerk kamu hastanelerine aktarılmasının zamanının geldiğine inanılmaktadır. Kanun tasarısı ile ülkemiz şartlarına uygun kamu hastane birlikleri oluşturulması öngörülmüştür. Hastanelerin madde ve insan gücü anlamında her türlü kaynağı merkezden sınırsızca talep etmeleri yerine kendi kaynaklarından sorumlu birlikler haline dönüştürülmeleri amaçlanmaktadır." "Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı," 6 March 2007 http://www2.tbmm.gov.tr/d23/1/1-0439.pdf.

189 "Birliğin organları yönetim kurulu, genel sekreterlik ve hastane yöneticiliklerinden oluşur. Yönetim kurulu birliğin en üst karar organıdır ve aşağıdaki üyelerden oluşur. İl Genel Meclisi tarafından belirlenen hukuk öğrenimi görmüş bir üye, İl Genel Meclisi tarafından belirlenen yeminli mali müşavir veya serbest muhasebeci mali müşavir bir üye, vali tarafından belirlenen işletme, iktisat veya maliye alanında en az dört yıllık yüksek öğrenim görmüş görmüş bir üye, ticaret ve sanayi odası veya bunların ayrı kurulmuş olması halinde ticaret odası tarafından belirlenen, en az dört yıllık yüksek öğrenim görmüş bir üye. İl sağlık müdürü veya ayny ilde birden fazla birlik bulunmasıhalinde bakanlıkça belirlenecek il sağlık müdür yardımcılarından birisi." "Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı" 6 March 2007 http://www2.tbmm.gov.tr/d23/1/1-0439.pdf.

190 “Uygulamanın sonuçları pek parlak değil. Reçetelendirmede doktorların ilaç yazmasının kısıtlanması ile başlandı. So ra ilaçta kısıtlamalara gidildi. Şimdi 1-2 YTL'lik ilaçların reçetesiz satılması gibi bir uygulama baslatacaklar. Bu ilaçların fiyatları artacak. Sağlıkta dönüşüm bir liberalleşme dönüşümüdür. Programın uygulanmaya başlamasından bu yana ilaç harcamalari yüzde 44 arttı. Dünyanın en hızlı büyüyen ilaç pazarı olduk. 2010 yılında dünyanın en büyük 10 ilaç pazari içinde olacağız.” *Cumhuriyet*. 2006. “Türkiye Sağlıkta Dönüşüm Problemi Yaşıyor.” December 7, 2006. 5.

191 "Tip Kurumu genel sekreteru Ali Rıza Üçer, eczacıların içine suruklendigi krizin AKP hükümetinin sağlıkta dönüşüm programının kacinilmaz bir sonucu olduğunu belirtti. Yaklaşık 2 yıl önce hazırlanan "Tıp Kurumu- Ankara Ticaret Odasi İlaç Raporu/ İlaçtaki Ur: Dışa Bağımlılık" raporunda eczacilarla öngörülerini sakladıklarını anımsatan Üçer uyarıları yeniledi : Yeni sistemin ardından sosyal güvenlik kurumları ilaç geri ödemelerini aksatacak ya da durduracak. Bu durum depolardan kısa vadeli ilaç alımı yapan binlerce eczanenin krize girip batacağı endişesini de beraberinde getiriyor. Kamu İlaç alım protokolu küresel bir planın parçası ve ulus ötesi şirketlerin bir operasyonu. Eczanelerin kapanmasının ardından tıpkı batı ülkelerinde olduğu gibi büyük alışveriş merkezlerinde ilaç satışı uygulaması yaygınlaşacak. Bu da ilac tekellerinin kârına kâr ekleyecek. Türkiye ilaç harcamaları 2005 yılında 3 milyar dolar artacak, bu kaynak uluslararası ilaç şirketlerine transfer edilecek. Türkiye kaybedecek ve ulus ötesi şirketler kazanacak." *Cumhuriyet*. 2007. “Eczacı Faiz Sarmalında,” January 16, 2007. 12.

192 "Aile doktoru olacak hekimler sozlesmeli statüde çalışacak, iş guvencesinden ve sosyal haklardan mahrum kalacaktır. Sağlık ocaklarında işleri ekipler yürütür. Hekim parasını pazarlıkla kazanmak zorunda bırakılınca ekip ruhu ortadan kalkacak, deger erozyonu yaşanacaktır." *Cumhuriyet*. 2003. “İş Güvencesi Yok,” November 25, 2003.

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