

## **Weak Informal Security Regime, Failing Health Care System: An Alternative**

### **Explanation of Reform in Turkey<sup>1</sup>**

*(Draft, Please Do Not Quote)*

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#### **1. Introduction**

Turkish welfare regime has been undergoing major transformation since the mid-1990s. Many governments tried to shape this transformation, sometimes with ambitious proposals, at other times with incremental policy fixes. The ‘Health Transformation Program’ (HTP) that was announced by the incumbent Justice and Development Party (JDP) in 2002 is one comprehensive attempt to shape the evolution of the health care system. This paper focuses on this reform program and aims to explain the reform imperative of the JDP with reference to the changes observed in the health care system. Going beyond the standard explanation offered by the critics of the reform attempts in developing countries, that is, they are imposed by the international financial institutions, most notably World Bank and the IMF, the paper aims to examine how the formal and informal components of the system transformed in response to major shifts in the model of economic development adopted by Turkish governments and wider socio-economic factors like persistent and frequent economic crises, growing informal sector, rapid urbanization, etc. It claims that the HTP must be explained as part of the JDP government’s wider social policy concern with controlling the effects of these socio-economic transformations on Turkish society, most important being rising poverty and social inequality.

Benefiting extensively from extensions of the welfare regime approach, offered by Seekings and Gough et. al.<sup>2</sup> and building on the emerging literature on the Turkish welfare

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regime<sup>3</sup>, Turkish welfare regime can be defined as a ‘inegalitarian corporatist system’ which guarantees for most formal sector workers employment-related benefits but at the same time excludes wide sections of the population. To meet the security needs of this latter group, an ‘informal security regime’, to use Gough’s terminology, has emerged which is largely based on community and family relationships. This paper demonstrates that this extension of welfare regime approach helps us understand the dual nature the Turkish health care system, which contains components of formal and informal mechanisms identified in the wider welfare regime. But, perhaps more importantly, it also helps us understand the transformation of the welfare regime which, the paper asserts, accounts for the growing pressures of reform in the health care system. Based on a field study that consisted of twenty in-depth interviews<sup>4</sup> with Turkish citizens who were uninsured or had Green Card at the time of the interview but previously been uninsured, it argues that in health care the shift towards universalism can only be explained as part of the weakening of some components of the informal pillar and declining legitimacy of the inegalitarian corporatist insurance system.

The paper is organized into four main sections. The second section describes the Turkish welfare regime building on the works of Seekings (2004) and Gough et.al.(2004). The third section then examines the evolution of the formal and informal pillars of the health care system while highlighting its major problems. The following section focuses on the post-1980 transformation of the Turkish polity and analyzes the transformation of both pillars in

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<sup>2</sup> Jeremy Seekings, “Prospects for Basic Income in Developing Countries: A Comparative Analysis of Welfare Regimes in the South.” Paper presented at the *BIEN Conference on The Right to a Basic Income: Egalitarian Democracy*, Barcelona, 20 September 2004; Ian Gough and Geof Wood with Armando Barrientos, Philippa Bevan, Peter Davis and Graham Room, *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts*, (Cambridge: Cambridge University Press, 2004)

<sup>3</sup> See Buğra and Keyder, *New Poverty and the Changing Welfare Regime of Turkey*; Buğra and Keyder, “The Turkish Welfare Regime in Transformation”; Buğra, Ayşe, “Ekonomik Kriz Karsısında Türkiye’nin Geleneksel Refah Rejimi.” *Toplum ve Bilim*, 89, (Summer 2001): 22-30; Günel, “Health and Citizenship in Republican Turkey”.

<sup>4</sup> The field study was carried out by the author in June 2009 at four different districts of İstanbul (Cekmekoy, Ihlamurkuyu, Tarlabasi, Sariyer) where lower-income socio-economic groups live. Ihlamurkuyu receives recent waves of migration whereas migration to others are somewhat stabilized. Tarlabasi is peculiar for having received Kurdish migrants from South Eastern Turkey. While some interviews were conducted with individuals, two of them were conducted with participation of more than two members of a family.

response to major social, economic and political changes. The conclusion aims to bring together all these discussions and tries to answer the question of to what extent HTP can be analyzed as a response to the crisis of the formal and informal pillars of the health care system. Another important question that also needs to be addressed is the concurrence of the interests of the JDP, the business elites and international policy actors. By attempting to answer these questions the paper aims to provide a comprehensive analysis of major forces driving policy reform in Turkey.

## **2. Theorizing Turkish Welfare Regime**

### **2.1 Seekings' Typology and Turkish welfare system**

Adopting a comparative, historical analysis of the development of 'welfare' systems in developing countries, Jeremy Seekings develops a new "three worlds" typology. Just like many alternative typologies that build on Esping-Andersen's seminal work on welfare regimes, Seekings also starts from a criticism of Esping-Andersen's approach saying that it is inadequate in 'Southern conditions' due to 'its neglect of the ways in which states influence distribution through shaping the development or economic growth path'.<sup>5</sup> He develops a three-fold alternative typology that focuses on the state's efforts to maintain income security: *agrarian, inegalitarian corporatist and redistributive welfare regimes*.

Agrarian regimes, in Seekings' typology, is characterized by the private provision of welfare, dependent on access to land and/or kin, where states sought to promote income security through a set of supportive state policies most important being land reform or subsidizing agricultural sector. Inegalitarian corporatist regimes, on the other hand, can also be called employment-based because, just like Bismarckian corporatist systems, they are defined by achieving income security through forms of risk-pooling and/or saving that are

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<sup>5</sup> J. Seekings, "Prospects for Basic Income in Developing Countries: A Comparative Analysis of Welfare Regimes in the South," Paper presented at the *BIEN Conference on The Right to a Basic Income: Egalitarian Democracy*, Barcelona, 20 September 2004: 1.

dependent on membership of occupationally-defined corporate groups. The ‘inegalitarian’ component refers to the systemic exclusion of the poor from formal employment and hence of the formal insurance system. Third, the redistributive regimes are defined by their recognition of citizens’ rights to income security through, especially, non-contributory social assistance. Seekings also point out that these are ideal types and that in practice, the welfare systems in countries combine elements of two if not all three of these kinds of regime.

This typology obviously helps us understand the welfare systems in countries which do not have mature welfare states but which at the same time are trying to restructure their welfare systems within a world where the latter shaped the policy environment significantly. Among the three types, the ‘inegalitarian corporatist’ one seems to be the one that best describes the Turkish welfare system, a formal social insurance system that provided social protection to privileged groups and excluded rural populations and the urban poor. In the post-World War II environment which emphasized state-directed economic development, important steps were taken “top-down” in the direction of creating a social insurance system to provide some degree of protection to the privileged sections of the population, namely the industrial working class and the civil servants. Especially before the 1960s, the political leaders believed that urbanization and industrialization in the Turkish context would be accompanied by the expansion of formal sector employment in manufacturing, industrial or service sectors. Since the social insurance funds which were established in late 1940s would expand accordingly to guarantee certain levels of security for their members and their dependents, most of the population would hence be covered by the social insurance system. Priority was rather assigned to ‘the problems of the farmer and the countryside’<sup>6</sup> and thus major social reform initiatives, including those in health care, were targeted to the countryside.

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<sup>6</sup> Buğra quotes, *Adnan Menderes*, who acted as the country’s prime minister through the DP rule in the 1950s, as saying, “In our country, social justice, rather than being a matter of concern for the problems of the proletariat, is a question pertaining to the problems of the farmer and the countryside.” “Poverty and Citizenship,” 42.

In short, unlike in Western European countries, the focus of social and economic policy in Turkey was not the industrial sector but the state aimed to improve the conditions in rural areas through agricultural support programs. Adopting Seekings' terminology, it can be argued that the inegalitarian corporatist system incorporated some elements of the agrarian regimes: private provision of welfare was the only option for many who were left out of the formal system, and family ties remained important in rural areas not only to access health services but also to maintain basic livelihood. In this regime, rather than developing formal insurance mechanisms, the state tried to support family as an important agent of welfare provision.

However, with the 1960 military coup which also marked the starting point of the national developmentalist project, a major transformation in the perception of social problems and welfare mechanisms to cope with these social problems can be observed among the political (and military) leaders. The prevailing Keynesian ideology which was largely associated with the golden age of welfare states was particularly resonant in Turkey: the civil and military bureaucracy began to emphasize social justice and acknowledged state responsibility to ensure citizen's welfare. This period witnessed growing levels of national integration and economic development, which constituted major goals of national developmentalism, and these gains were distributed to the citizenry through social entitlements such as expansion of public education or access to health services.

Despite this growing concern with universalism and citizens' welfare, it is not possible to argue that the Turkish welfare system evolved towards a European type welfare state. Rather, a dual welfare structure emerged which consisted of formal social security schemes for the industrial workers and civil servants and an informal welfare system to provide some degree of protection to those left out of the formal system. While Seekings' analysis is very helpful for studying the diverse roles played by states to ensure some degree of security to

their citizens, in order to be able to account for this dual structure and important role played by the informal welfare mechanisms in urban areas, we need a different conceptualization of the welfare regime. The next section turns to Gough et.al (2004)'s work which provides a sophisticated theoretical framework that accounts for the changes in Turkish welfare regime.

## **2.2 Insecurity and the Turkish Welfare Regime**

Starting from Esping-Andersen's 'welfare regime paradigm', Ian Gough and his colleagues initiated a research program at the University of Bath which basically aimed to examine the social policy regimes in the South. The research program retained the idea of 'regime' which was defined as 'repeated systemic arrangements through which people seek livelihood security for their own lives and those of their children and descendants'<sup>7</sup>, but they revised it somehow to be able to explain the different nature of welfare structures in developing countries where citizens are not generally guaranteed long-term rights and thus engage in wider strategies of security provision. Particularly they draw attention to the differences in welfare mixes of developing countries, which, unlike the mature welfare states, do not privilege the state as the key institutional actor. They argue that although the state is an important actor, the policy terrain in these countries are also marked with significant roles played by the community as well as international institutions, which must be analyzed as part of their particular welfare regimes.

Within this analytical framework, the Bath researchers classify different regions of the world into three families of welfare regimes: *welfare state regimes*, *informal security regimes* and *insecurity regimes*. In a welfare state regime, people, whose rights to a range of social services and cash benefits are formally recognized, are expected to meet their security needs through participation in labor markets. This regime is premised on capitalist economies, formal labor markets, relatively autonomous states and well-entrenched democratic

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<sup>7</sup> Ian Gough and Geof Wood, "Introduction," in *Insecurity and Welfare Regimes in Asia, Africa and Latin America*, eds. Ian Gough, Geof Wood, Armando Barrientos, Philippa Bevan, Peter Davis and Graham Room (Cambridge: Cambridge University Press, 2004): 5.

institutions. In an informal security regime, on the other hand, people rely heavily on community and family relationships to meet their security needs. In the absence of formally recognized rights, poor people can only get some short-term security for longer-term vulnerability and dependence as well as problematic inclusion. Patron-client relations are pervasive in these welfare systems. Finally, an insecurity regime is defined by insecurity, vulnerability and suffering for most citizens because combination of powerful external players and weak internal actors generate a permanent state of uncertainty and political instability. Under these conditions neither formal social security mechanisms nor stable informal mechanisms can emerge.

One of the leading researchers in the Bath program, Ian Gough, tried to map empirically these welfare regimes in the developing world, and his analysis produced four clusters on the basis of two indicators of the welfare mix – public spending and international flows of aids and remittances: *actual or potential welfare state regimes; more effective informal security regimes; less effective informal security regimes and externally dependent insecurity regimes*. While Turkey is not included in this analysis except for a brief reference, with its above-average welfare outcomes in all areas – that is life expectancy, literacy and freedom from poverty - and below-average levels of public expenditure, it seems to belong to either the first or the second category. But more important than this mapping is the extent to which this extended welfare regime approach can provide a framework for a comprehensive analysis of changes in the Turkish welfare system. As already been discussed, after 1960, Turkish welfare system attained a dual character which, to use Gough et.al. (2004)'s terminology, combines elements of a welfare state regime and an informal security regime: a social insurance system exists for the formal sector workers and civil servants but excludes large segments of the rural populations as well as the urban poor and the new migrants in

cities. These excluded groups then developed informal mechanisms to cope with rising poverty.

Especially in identifying the characteristics of the informal mechanisms in urban areas this paper relies heavily on Wood's 'informal security regime' which highlights the different conditions faced by the informal sector workers and the poor. While the state aimed to improve the conditions in the countryside, massive migration to the cities continued during the 1950s and 1960s. Despite rapid industrialization and increase in the number of State Economic Enterprises (SEEs) which aimed to provide employment while at the same time acting as engines of economic development, the number of workers covered by the workers' fund increased to 577,991 in 1960 from 466,852 in 1955, corresponding to 4.37 and 4.78 percent of the active population, respectively.<sup>8</sup> Therefore, this new labor force that entered urban labor markets through migration and urbanization remained insecure in these markets.

The segmented nature of the labor market was consolidated between 1960 and 1980 during the period of national developmentalism which adopted import-substituting industrialization (ISI) as major economic policy. Although rapid urbanization in the 1960-80 period was accompanied by high rates of industrialization – growth rate was about 10% per annum- , the modern industrial sector nevertheless could not accommodate all the labor force flowing into the cities. The ratio of urban population to total population had gone up from 30.54 per cent in 1960 to 37.05 per cent in 1970 and 42.84 per cent in 1980<sup>9</sup>, and only one third of this population could find employment in the modern industrial sector. The majority of the newcomers to the cities worked in small industries, services or petty commerce where employers could evade social security regulations.

In the absence of rights-based social policy mechanisms which provided social protection and/or social assistance regardless of the employment status, the informal sector

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<sup>8</sup> N. Özbek, *Cumhuriyet Türkiye'sinde Sosyal Güvenlik ve Sosyal Politikalar* (İstanbul: Emeklilik Gözetim Merkezi.Tarih Vakfı, 2006), 244.

<sup>9</sup> Source TÜSİAD, *Turkey's Window of Opportunity*, 54

workers continued to rely on community and family relationships to meet their security needs. While the remaining members of the family in the village continued to support the migrant by sending money or supplies in kind, those relatives or neighbors who came earlier to the cities provided them with assistance in the urban environment. The newcomers benefited from cheap housing opportunities such as renting the irregular houses built on state land or building one for themselves, as the state allowed and even encouraged these informal practices by providing these houses with basic infrastructure (sewage and drainage systems, clean water and electricity and other municipal services such as garbage removal) as well as giving titles of the property especially during the municipal elections.

In this way, an informal security regime, as identified by Wood<sup>10</sup>, emerged alongside the formal system of social protection, which until the adoption of market principles with the 1980 coup, addressed the question of poverty in cities. Such a dual welfare structure tended to reinforce socioeconomic inequalities between the formally insured and uninsured as well as between the rich and the poor. In this system, instead of establishing formal mechanisms aimed at breaking the cycle of poverty, social protection for the poor and vulnerable populations living in both urban and rural areas was left to families and communities.

The state elite which were in charge of directing the socioeconomic transformation of the country did not seem to be concerned with these informal networks and practices. First of all, this welfare mix, which assigned community and family greater responsibility in ensuring the welfare of the citizen, lifted some of the burden from the state while at the same time serving as a major mechanism for social inclusion. But secondly, as already been indicated, there was the prevalent expectation among the policymakers that, with rapid industrialization, a growing percentage of the new migrants would be employed in the formal sector and that it

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<sup>10</sup> G. Wood, "Informal Security Regimes: the strenght of relationships," in *Insecurity and Welfare Regimes in Asia, Africa and Latin Americas: Social Policy in Development Contexts*, eds. I. Gough and Geof Wood with Armando Barrientos, Philippa Bevan, Peter Davis and Graham Room (Cambridge: Cambridge University Press, 2004). Also Buğra explains these informal mechanisms in terms of an "informal pact" between the state and people, which was outside the legislative process. See Buğra, "Poverty and Citizenship", 42-45.

was just a matter of time for the formal social insurance system to expand and limit, if not completely eliminate, the informal welfare system.<sup>11</sup> The state elite, therefore, allowed the continuation of the informal practices by refraining from establishing a tighter regulatory mechanism which could have prevented misuse or fraud. But by doing so, it perpetuated the dual welfare structure which has significantly shaped the domestic interests and perceptions which then acted to preserve the existing system. Especially the unions emerged as major actors who defended the status-based insurance system against any reform initiative and preserved their privileges.

But starting in the 1980s, under the conditions of urbanizing labor markets which are highly segmented, expanding service industry, precarious employment as well as changing structure of families, both the formal and informal pillars of this dual system underwent significant transformation, leaving new migrants as well as the rural populations more insecure. This transformation, the paper argues, has contributed to the perceived need for reform during the 2000s. But before discussing the reform, the next section provides a brief description of the evolution of the health care system in Turkey.

### **3. Turkish health care system: Corporatist and Informal at the Same Time?**

The first social insurance schemes (funds) for workers (Social Insurance Institution-SII) and state employees (Retirement Fund) were created in the aftermath of the Second World War, partly in response to the favorable international environment that was marked with the rise of the welfare state in Western Europe. The first initiative to set up a national health insurance also dates back to the immediate aftermath of the war. Although it could never be implemented, it was important in terms of demonstrating the concern of the bureaucrats with the situation of rural Turkey.

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<sup>11</sup> Ç. Keyder, "Health Sector Reform in the Context of Turkish Political Economy," paper presented at the *Workshop on Health Reform in Comparative Perspective*, Social Policy Forum, June 17-18, (Boğaziçi University, İstanbul, 2005).

These two events, establishment of social security schemes and the failure to create universal insurance, significantly shaped the path of subsequent policy development. In the 1960-80 period, the changes in the international economic environment with the rise of American hegemony, the adoption of state-led industrialization model and particular constellation of dominant groups reinforced the social insurance system which was highly fragmented and unequal and which left large segments of population, the rural populations as well as the urban poor, excluded from the system. Even the comprehensive reforms like 1961 Law on the Socialization of Health Services could partially be implemented and was reduced to an attempt at reforming the primary care infrastructure of the country. It was in this period that we talk about the entrenchment of the dual ‘corporatist inegalitarian’ welfare regime and ‘corporatist-informal’ health care system.

Failure to establish a single payer system led to alternative proposals to extend the insurance to the rest of the population by creating additional social security institutions as well as redefining the scope of the existing ones so that majority of the population would have some coverage. A major step in the consolidation of the social insurance system was the Social Insurance Law<sup>12</sup> which expanded the coverage of Social Insurance Institution (SII) to include all workers in manufacturing and industrial sectors regardless of the size of the workplace (previously only those employers who employed more than 10 workers in their workplaces were obliged to contribute to the SII).<sup>13</sup> The third insurance fund, Bağ-Kur<sup>14</sup>, was established in 1971 as a social security institution for the self-employed, artists and small

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<sup>12</sup> *Sosyal Sigortalar Kanunu*, no. 506, *Resmî Gazete*, 29, 30, 31 July and 1 August 1964.

<sup>13</sup> However, there was still no insurance coverage for the people working in the agricultural sector. This gap was partially filled with the Law no. 2100 in 1977 which included workers in the agriculture with a permanent contract of service as well as those who did housework permanently with a salary within the Social Insurance Institution (SII). But in practice, only a small portion of those in agriculture (16,647 in 1981 and 165,268 in 2003) could be included. See Özbek, *Cumhuriyet Türkiye’sinde Sosyal Güvenlik ve Sosyal Politikalar*, 284-86.

<sup>14</sup> 2/9/1971, law no: 1479.

bourgeoisie as well as the local administrators (muhtar) in villages and neighborhoods.<sup>15</sup> In 1983 with Law no 2926 (so-called Bağ-kur Law for Agriculture) those people working for themselves in the agricultural sector became eligible to become members of Bağ-Kur. Yet, until 1986 Bağ-Kur covered only old-age, disability and death risks; health insurance was added in 1986 with the Law no. 3235. Finally, with a legislation dated 1976 the responsibility of providing pensions to those people over 65 who were poor or disabled was given to the Retirement Fund. Health services, on the other hand, would be provided to these people at public hospitals with no payment required.

When we come to 1980, we can see the emergence of the main contours of social security system which covered 38.4% of the population<sup>16</sup>. This was a fragmented and hierarchical system of a corporatist character combining health and pension benefits. Significant differences existed among social insurance funds in terms of the premium rates, benefit packages and co-payments as well as the quality of the services provided by health care institutions, which constituted one of the major reasons for reforming the health sector in the following two decades. For instance, the Retirement Fund for state employees has always had a special place among the three agencies in terms of generosity of pension (and health) benefits it provided relative to contributions collected.<sup>17</sup> Next came the SII members who had privileged access to their own hospitals which in theory were solely dedicated to their health problems. Yet, in practice, these hospitals were very crowded places characterized with long waiting times, chronic shortage of personnel and high-technology equipment as well as low morale of both health personnel and patients. Finally, those Bağ-Kur members who paid health insurance premiums, could benefit from public hospitals and

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<sup>15</sup> These groups were obliged to become members of the fund but the membership was also opened with Law no. 2229 dated 4 May 1979 on a voluntary basis to other groups, such as housewives and those people with no social security but would like to get public health insurance

<sup>16</sup> OECD, Health Data 2006 Database, CDROM, for more information, <http://www.oecd.org/health/healthdata/>

<sup>17</sup> S. Sayan, "Political Economy of Pension Reform in Turkey," in *The Turkish Economy: the real economy, corporate governance and reform*, eds. S. Altuğ and A. Filiztekin, 252-275 (London and New York: Routledge, 2006), 258.

other health facilities which signed contracts with the fund, but due to chronic balance of payment problems, the institution was famous for delays in payments to hospitals. Therefore, many facilities did not want to admit Bađ-Kur members, and when they were admitted these patients received low-quality care.

Although this system is generally described as ‘corporatist’, this hierarchy where the civil servants were at the top was not based on the level of contributions. Unlike the corporatist systems in Europe, the link between contributions and benefits has always been weak in the Turkish insurance system: not all members paid contributions and it was not a system where those people who pay more contributions received better services. Rather the hierarchy was based on the closeness to the state and on the employment status. As Üstündađ and Yoltar point out the state established differential relationships with its citizens by means of different social security schemes.<sup>18</sup>

While there were many reform attempts during the 1960s and 1970s, none of them could succeed to restructure the system completely. One major reform attempt was the Law on Socialization of Health Services that was passed by the military government in the early 1960s. However, for reasons that are beyond the scope of this paper, it could only be partially implemented which in turn led to the creation of a mixed system: by the 1970s, a primary care system was established to provide health services to the rural populations, and to some extent the urban poor, alongside a growing hospital sector which was concentrated in urban areas and served the insured.

Yet, even this primary care system that was aimed to provide basic curative and preventive care to the uninsured did not work properly. Significant inequalities in the distribution of health personnel and facilities remained a major problem. Huge gaps have been reported in the distribution of health personnel among the provinces and regions; in particular,

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<sup>18</sup> N. Üstündađ and Ç. Yoltar, “Türkiye’de Sađlık Sisteminin Dönüşümü: Bir Devlet Etnografisi,” in *Avrupa’da ve Türkiye’de Sađlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds. Çađlar Keyder, Nazan Üstündađ, Tuba Ađartan and Çađrı Yoltar (İstanbul: İletişim Yayınları, 2007)

there was a concentration of physicians in the big cities and towns and rural areas were significantly understaffed.<sup>19</sup> As a recent World Bank report points out 12 per cent of health centers lacked a GP whereas two thirds of all health posts lacked a midwife, implying that the vast majority of rural posts were not functional.<sup>20</sup> Especially in underdeveloped regions such as Southeastern Anatolia the failure of primary care had even worse implications since these were the places where lower incomes and higher share of population not covered by health insurance made it more difficult to access few alternative primary care providers such as the SHI or private dispensaries. When difficulties in reaching urban areas particularly in winter added to this picture, we can see that significant problems of access to primary care have existed for rural populations in Turkey.

The situation was no better for the urban populations. In the cities, where almost 44 percent of the population lived in 1980, primary care centers tried to provide basic health services to the poor and the uninsured working population. But given the rapid urbanization Turkey experienced since 1960 the health centers soon fell short of meeting the rising demand for health services in urban areas and flow of uninsured patients to the public hospitals deepened the crisis of secondary care.

The 61.6% of the population who were not formally covered by social health insurance developed their own 'informal' ways of accessing health services. On paper, the uninsured in both urban and rural areas had access to basic primary care. But what happened when they had more complicated health problems? As in other developing country contexts, an informal welfare system emerged alongside this formal system to cater the needs of the rural populations or shanty town dwellers in terms of providing access to free or lower-cost

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<sup>19</sup> In 1980 there were 1467 health centers and 5776 health posts, see Ministry of Health, *Health Statistics 2002* (Ankara, MoH: 2003), 69. A recent World Bank report demonstrates that 665 health centers (12%) do not have a doctor and two thirds of all village health posts do not have a midwife in 2001. See World Bank, *Turkey Reforming the Health Sector for Improved Access and Efficiency, Vol I*, Report No. 24358-TU (World Bank: Washington D.C., March 2003a), 12.

<sup>20</sup> World Bank, *Turkey Reforming the Health Sector for Improved Access and Efficiency, Vol II*, Report No. 24358-TU (World Bank: Washington D.C., March 2003a), 52.

treatment in hospitals. In this informal system, family and community assumed important roles both in terms of facilitating access to hospitals and providing financial support to pay hospital bills. Many of the uninsured relied on their families and borrowed from their relatives when they could not pay the hospital bills. Second, the uninsured members of the family used the social security cards of one of their relatives when they had to go to a hospital. There were many stories of fraudulent use of social security cards, like a couple taking the child of their close kin as their own child to a doctor and getting treatment or a SII card that indicated that appendicitis surgery was done eight times on the same person. Third, a relative or an acquaintance served a particularly important role if s/he worked in a health facility in any capacity. There is a saying in Turkey which represents the importance of knowing someone who works in a hospital: 'if you have a man working in a hospital, your job is done'. The 'man' can take appointments, get free treatment from doctors, provide free drugs, reduce waiting times, etc. The 'man' can also significantly facilitate access by guiding you through the complex health system, telling you what to do next and how to do it.

Despite their 'illegality', the hospital administrators and doctors turned a blind-eye to practices such as using other people's insurance cards or requests to provide free services. Some doctors, especially in primary care, even encouraged these 'fraudulent' practices by asking whether the uninsured sick person knew anyone with social security. They would then use that insurance mostly to write prescriptions and save the uninsured from the burden of paying for prescriptions. This practice makes more sense if one takes into account the different perceptions of what constituted 'fraud': neither the hospital administrators nor the Ministry of Health bureaucracy seemed to consider using other people's cards as a 'fraudulent practice' and thus punished the health staff for these types of practices. Everybody was aware of the problems of access experienced by the uninsured and believed that the state should provide services to these people somehow.

The health care staff or the political leaders could pretend not to see this informal system also because of the financial structure of the system. The insurance institutions paid the bills without close inspection and when they announced budget deficits, they were criticized publicly but then transfers were made regularly from the central state budget to keep them running. This was an indirect way of subsidizing the social insurance funds which paid more than they should given the number of enrollees in the books.

All of this made sense in a political environment where the state was seen as ‘a father who protects all of his citizens’ and in an economic environment where economy was growing, wages were increasing and peasants were protected through agricultural subsidies: with these rates of urbanization and industrialization, it was a matter of time for the social protection system to expand and cover the whole population. Until then it was OK for the uninsured to cope with problems of access with these ‘harmless’ informal mechanisms. Reliance on the family and community networks also constituted an important part of this welfare system: these networks filled in the blanks left by the formal system. But the state tried to support the family through agricultural support programs in the villages or allowing cheap housing opportunities on state land in urban areas, while also indirectly subsidizing the care provided to the uninsured when necessary. However, in late 1970s, combined with the political instability and polarization, the economic crisis brought about another military intervention and initiation of a new economic policy in its aftermath. These implied significant changes for the welfare system and the health system.

#### **4. Transformation of the Turkish Welfare System in the Neoliberal Era**

The military intervention of 12 September 1980 represented one of the most important turning points in Turkish history, not only because it brought about the transformation of the political system, but also facilitated the implementation of the new economic orthodoxy.

Under the leadership of a civilian technocrat, Mr. Turgut Özal, major policies of stabilization and structural adjustment were carried out. These new economic policies represented a structural change in the Turkish economy towards the adoption of market principles and a subsequent redefinition of the role of the state in the economic sphere which implied a fundamental break with the previous policy of national developmentalism. The coup was in this sense less ‘bureaucratic-authoritarian’ and more ‘in line with the Thatcher-Reagan era neo-liberalism’.<sup>21</sup>

Quite similar to the experience of Latin American or East and Southeast Asian countries, closer integration with global economy implied for Turkey growing vulnerability to economic crisis.<sup>22</sup> The Turkish economy during the 1990s experienced persistent instability mainly caused by high rates of external and internal debt, chronic fiscal deficits, high rates of inflation as well as high inflows of short-term speculative capital which increased its vulnerability. The first economic crisis emerged in 1994 which was followed by a more severe crisis in 2001. Both crises resulted in rapid economic contraction which was further associated with massive job losses, decreases in real income, and sharp drops in the purchasing power of households.

So, what were the implications of all these changes on the welfare system? To answer this question we need to consider the changes in both the formal and informal welfare mechanisms. First, as Esping-Andersen and many others in welfare state literature have pointed out it was no longer possible to achieve the equality/full-employment nexus that

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<sup>21</sup> Keyder, *Ulusal Kalkınmacılığın İflası* (İstanbul: Metis, 1993). Some observers went as far as to argue that the coup was done to further the interests of some segments of the bourgeoisie and that it was supported by this group. See Sungur Savran “20. Yüzyılın Politik Mirası”, in N. Balkan and S. Savran (eds.) *Süreklili Kriz Politikaları*, (İstanbul: Metis, 2003), p.13-43. See also K. Boratav, “Contradictions of "Structural Adjustment": Capital and the State in Post-1980 Turkey,” in *Developmentalism and Beyond: Society and Politics in Egypt and Turkey*, eds. A. Öncü, Ç. Keyder, S. İbrahim, 155-177 (Egypt: The American University in Cairo Press, 1994).

<sup>22</sup> Morse argues as early as 1972 that the three facets of market integration- trade, multinational firms and international finance- posed a grave threat to national autonomy in terms of restricting the freedom of governments to set domestic as well as foreign economic policies. E. L. Morse, “Transnational Economic Processes,” in *Transnational Relations and World Politics*, eds. R. O. Keohane and J. S. Nye, 23- 47 (Cambridge, Mass.: Harvard University Press, 1972), 23).

characterized the Golden Age of welfare states.<sup>23</sup> This implied, for countries without mature states, the end of hopes for replicating the example of the welfare states and establishing universal coverage based on employment. Changes in international economy such as de-industrialization, shift of manufacturing to low-wage countries, rising importance of the service economy, and spread of flexible employment practices that are associated with post-Fordist production practices shattered the developmentalist expectations that economic development would be accompanied by the expansion of formal sector jobs with social security benefits.

To make matters worse, in the new economic environment employment opportunities in the formal sector declined while the relative weight of sectors changed considerably: reflecting a common trend in other developing countries, share of agriculture has been shrinking with deruralization.<sup>24</sup> Especially in the last three decades, more than 1.5 million people left rural areas and agricultural employment declined from 31.24% in 1988 to 43.36% in 2003 and to 26.4% in 2007.<sup>25</sup> On the other hand, share of industrial employment rose very little between 1988 and 2003<sup>26</sup>, while share of services expanded from 31.24% to 43.36%.<sup>27</sup>

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<sup>23</sup> See Esping-Andersen, *Welfare States in Transition*. There are many studies in welfare state literature which talk about the inability to sustain, in the global age, the mechanisms of employment protection that were available to governments in closed economies. See E. Huber, "Options for Social Policy in Latin America: Neoliberal versus Social Democratic Models," in *Welfare States in Transition. National Adaptations in Global Economies*, ed. G. Esping-Andersen, 141-91 (London: Sage, 1996); A. Barrientos, "Latin America: towards a liberal-informal welfare regime," in *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts*, eds. Gough, Ian and Geof Wood with Armando Barrientos, Philippa Bevan, Peter Davis and Graham Room, 121-168. (Cambridge: Cambridge University Press, 2004); I. Gough, "Welfare Regimes in development contexts: a global and regional analysis," in *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts*, eds. I. Gough and Geof Wood with Armando Barrientos, Philippa Bevan, Peter Davis and Graham Room, 15-48. (Cambridge: Cambridge University Press, 2004); H. Kwon, "Transforming the Developmental Welfare State in East Asia," *Development and Change*, vol.36, no.3 (2005): 477-497.

<sup>24</sup> See Table 3

<sup>25</sup> TUIK (Turkish Statistical Institute), Household Survey 2007 (accessed at April 2008), available from [http://www.tuik.gov.tr/VeriBilgi.do?tb\\_id=25&ust\\_id=null](http://www.tuik.gov.tr/VeriBilgi.do?tb_id=25&ust_id=null)

<sup>26</sup> Although massive privatization of SEEs could not be carried out as planned, in the new economic context they ceased to function as a major source of employment. A major reason can be found in the MP governments' approach to SEEs which, especially prior to the 1987 elections, did not involve patronage politics (unlike JP governments). M. Heper and F. Keyman, "Double-Faced State: Political Patronage and the Consolidation of Democracy in Turkey," in *Turkey Before and After Atatürk*, ed. S. Kedourie (London, Portland, Or: Frank Cass, 1999).

One factor that explains low levels of job-creation in the industrial sector was the availability of labor-saving technology. Moreover, as many of the recent studies point out, export-oriented sectors relied more on the informal use of labor such as seasonal or irregular employment practices especially in tourism, working at home in apparel and textiles industries, employment on a non-contractual basis in manufacturing as well as service industries.<sup>28</sup> All these developments in the Turkish labor market indicated a reverse trend towards informalization where a large part of the workers had no social security coverage, and jobs were lower-paid and precarious. When we add to this bleak picture the high rates of unemployment which seems to be more long-term rather than temporary, it becomes obvious that the corporatist social security system cannot be relied on to provide security to a majority of the population. The coverage rates of social security funds as indicated in Tables 1 and 2 confirm this observation.

Second, as a result of the important changes in the socioeconomic structure of the country, various mechanisms of redistribution and social assistance, which aimed to create an “opportunity space” for the citizens outside of the formal social policy interventions, were no longer available. Here, we have to consider changes in the patterns of urbanization, the profile of the migrants, the conditions of the urban environment, and family structures in order to get a better picture of how the informal welfare mechanisms transformed and to what extent they have become inadequate and unsustainable. First, under the new economic conditions in which agricultural production was no longer assigned a priority, the new migrants could not count on income supplements, both in kind and monetary, from their relatives who had

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<sup>27</sup> A. Buğra and Ç. Keyder, “The Turkish Welfare Regime in Transformation,” *Journal of European Social Policy*, vol.16, no.3 (2006): 211-228.

<sup>28</sup> A. Buğra and Ç. Keyder, *New Poverty and the Changing Welfare Regime of Turkey*. Report Prepared for the United Nations Development Programme (Ankara: UNDP, 2003) and A. Buğra and Ç. Keyder, “The Turkish Welfare Regime in Transformation.”

remained in the village. Having to adopt the economic rationality of the market economy<sup>29</sup>, the Turkish policymakers could not continue supporting peasant agriculture with tax breaks and other subsidies. The new economic orthodoxy dictated a significant redefinition of the priorities of economic policy whereby trade in agricultural products was gradually liberalized and the emphasis has shifted to infrastructural activities.<sup>30</sup>

Second, especially the case of Kurdish immigrants during the 1990s represented a different form of rural–urban migration since they were forced to migrate due to the war conditions created by the rising armed conflict among the Kurdish separatists and Turkish military in East and Southeast regions. These people who came to cities had weaker ties with their villages and they could not benefit from the urban social networks as much as the first wave of migrants. A major factor that should be considered to explain the weakness of the social networks is the changes in the urban space since the late 1980s. Growing demand for urban land due to the new interest in suburban residential living, new emphasis on improving the infrastructure by expanding roads, opening highways as well as building large malls implied limited availability of land for irregular settlements by the new migrants.<sup>31</sup> Unable to live close to their relatives or co-locals, the new migrants were thus deprived of their support.

Finally, family’s role in providing support for its members has weakened considerably with the changes in the gender settlement and family structure, particularly from the changes in family structures. While indicators of change such as divorce rates, births outside of

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<sup>29</sup> Prime Minister Özal placed major emphasis on economic rationality and the economic and social policies of MP governments reflect his concern with the requirements of a market economy. As Heper and Keyman point out, economic decisions in this period were not dictated by clientalist demands but they were responsive to market signals. “Double-Faced State,” 266.

<sup>30</sup> Gradually the state withdrew from its role as a direct producer of manufactured commodities and placed more emphasis on infrastructural activities such as energy, transport and communications. See Ziya Öniş, “Political Economy of Turkey in the 1980s: Anatomy of Unorthodox Liberalism,” in *Strong State and Economic Interest Groups: The post-1980 Turkish Experience*, ed. M. Heper, 27-40. (Berlin, New York: Walter de Gruyter, 1991), 29.

<sup>31</sup> See Buğra, “Türkiye’de Sağ ve Sosyal Politika,” *Toplum ve Bilim*, 106 (2006): 43-67; Buğra “Immoral Economy of Housing in Turkey,” *The International Journal of Urban and Regional Research*, vol. 22,( June 1998): 303-317; A. Öncü, “The Politics of Urban Land Market in Turkey: 1950–80,” *International Journal of Urban and Regional Research* vol. 12, 1988, pp. 38–64; and O. Işık and M. Pınarcıoğlu, *Nöbetleşe Yoksulluk: Sultanbeyli Örneği* (İstanbul: İletişim Yayınları, 2001).

marriage or proportion of women in paid work<sup>32</sup> are extremely low, the nuclear family has become the norm in urban areas. With declining fertility rates and population aging, the nuclear families can no longer substitute for formal safety nets to provide care for the elderly or the children.

These changes in the structure of the welfare system, in turn, increased the burden on formal security mechanisms. As Buğra and Keyder point out, the growing percentage of the population working in the informal sector were dependents of formal sector employees, a situation which resulted in rising expenditures of social security institutions but low contributions<sup>33</sup>: the increasing dependency ratios meant growing deficits of social security funds which were met by the transfers from the central budget, an issue which occupied the center of attention during the 1990s.

These concerns with controlling social expenditures as well as the inadequacy of the dual welfare system to provide security and deal with the new poverty<sup>34</sup> brought the comprehensive reform of the welfare system to the political agenda. By the 1990s, the Turkish policymakers were aware of the fact that, within the confines of the inegalitarian corporatist system with very few social assistance mechanisms, they had very few tools in their discretion to cope with the threat of social disruption in the context of a market economy. This ‘novel consciousness of the importance of social policy’<sup>35</sup> marked many of the reform attempts since the late 1980, but more particularly during the 2000s. This novel consciousness, which was a global phenomenon shared by many policymakers in advanced

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<sup>32</sup> It was 33.1 in 1988 and decreased to 26.3 percent in 2001 which are very low compared to the EU-15 average of 54.9 percent in 2001.

<sup>33</sup> Buğra and Keyder, “The Turkish Welfare Regime in Transformation”, p. 226.

<sup>34</sup> Changes in the relationship between work and livelihood as well as in the spatial transformation of urban life that we discussed in this section are discussed under the term ‘new poverty’. See Buğra and Keyder, *New Poverty*; “The Turkish Welfare Regime in Transformation”.

<sup>35</sup> A. Buğra and S Adar. “An Analysis of Social Protection Expenditures in Turkey in a Comparative Perspective.” *New Perspectives on Turkey*, 38 (Spring 2008): 83-106. As early as 1983, MP governments emphasized the link between social and economic development and developed a social policy agenda to ensure social development. This agenda included ‘providing social justice and equality of opportunity, reducing regional inequalities, and expanding welfare’ and it can be seen in all MP government programs.

industrial countries as well as the developing countries, first took the form of widespread adoption of means-tested or targeted mechanisms such as affordable or free insurance for children or pensions for poor people over a certain age.<sup>36</sup> These policies were also accompanied by the spread of an increasingly powerful and convincing conservative approach that place more emphasis on the role of family, charity and voluntary organizations in providing social assistance to the poor.<sup>37</sup>

## **5. Corporatist-Informal Health System in the Neoliberal Era**

It is hard to describe any period in Turkish health care system in positive terms and it is even difficult to do this for the 1980-2000 period when the existing problems deepened and new concerns emerged. First, with regards to the organization of provision, health personnel shortages, inequalities in the distribution of facilities and personnel, problems with quality and efficiency at all levels of service provision, problems of accessing health facilities for a considerable percentage of the population, growing numbers of the uninsured, lack of a referral system and problems with primary care can be mentioned. Regional and rural-urban disparities remained a characteristic problem of the Turkish health care system as the key health indicators such as infant mortality, under-five mortality, maternal mortality, and immunization rates<sup>38</sup> indicated. Especially in the East and Southeast Turkey scarcity of nurses

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<sup>36</sup> Judith Tendler, "Why Social Policy is Condemned to a Residual Category of Safety Nets and What to Do about it?" in *Social Policy in a Development Context*, ed. T. Mkandawire, 119-142. (New York: Palgrave MacMillan, 2004).

<sup>37</sup> A. Etzioni, A. Volmert, and E. Rothschild, eds. *The Communitarian Reader: Beyond the Essentials*. (Lanham, MD: Roman and Littlefield, 2004) and Jenkins, S. "The welfare state is waning. Bring on the philanthropists." *The Guardian*, June 28, 2006, accessed April 2008, available from <http://www.guardian.co.uk/commentisfree/2006/jun/28/comment.policy>; internet

<sup>38</sup> A Study conducted by SwedeHealth which was published in 1994 describes the situation in 1994 as follows 'Compared with countries with similar economic and social status the health situation in Turkey is unsatisfactory. Avoidable mortality rate – that is, death rate due to causes that are preventable or controllable - is high. This is especially remarkable for infants, young children and women in fertile age groups. Although life expectancy is increasing, it is still lower than could be achieved'. SwedeHealth, "Restructuring and Management Development of the Turkish Ministry of Health" Final Report (1994), 7.

and midwives as well as the GPs was a chronic problem repeatedly discussed in major health policy documents.<sup>39</sup>

The situation was no better in the cities. The primary care centers could not meet the health needs of rapidly increasing urban populations and failed to serve as point of first contact. This placed additional burden on hospital outpatient facilities, which in turn increased waiting times and lowered quality of care.<sup>40</sup> While the total number of hospital beds in the whole country was not very low<sup>41</sup>, there were serious inequalities among the regions in terms of the quantity and the quality of hospitals. The lack of a well-functioning referral system; the widely shared public perception that real health care was provided in hospitals where more prestigious specialists worked and where the diagnostic tests and high-technology equipment were more readily available; and rising expectations of the curative power of medicine, altogether increased the patient load in hospitals substantially.

Yet, public hospitals were in no shape to meet this rising demand. The low levels of public expenditure heralded financial difficulties which forced the hospital administrators search for ways to generate their own resources. One common way to generate resources was through establishment of revolving funds, which also distributed profits to the doctors and other health personnel. This practice was criticized on the grounds that it constituted a step towards privatization as hospitals were considered as enterprises responsible for financing their own operations. Together with the proposals for adoption of new payment methods and

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<sup>39</sup> According to MoH data, 13 % of health centers lacked a GP whereas three fourth of all health posts lacked a midwife (MoH 2002). World Bank report provides similar results: 665 health centers (12%) do not have a doctor and two thirds of all village health posts do not have a midwife. See World Bank, *Turkey Reforming the Health Sector for Improved Access and Efficiency, Vol I and II*.

<sup>40</sup> Relying on hospital managers' estimates, World Bank report claims that at least 60%-70% of cases seeking care at the outpatient facility of the SSK hospital in Erzurum could be treated at the primary level and over half of all patients seeking care at the polyclinic of Erzurum's provincial MOH hospital could be treated at the primary level World Bank, *Turkey Reforming the Health Sector for Improved Access and Efficiency*, 60).

<sup>41</sup> According to OECD Health Data 2007, the number of acute care hospital beds in Turkey in 2005 was 2.0 per 1 000 population, about half the OECD average of 3.9 beds (accessed in April 2008); available from [http://www.oecd.org/document/30/0,3343,en\\_2649\\_37407\\_12968734\\_1\\_1\\_1\\_37407,00.html](http://www.oecd.org/document/30/0,3343,en_2649_37407_12968734_1_1_1_37407,00.html)

for experimentation with new models of hospital administration, these developments represented instances of introduction of markets into health care.

Another area where little progress could be achieved despite much talk was the reform of the health insurance system. Yet, the percentage of the uninsured expanded with rapid urbanization and expansion of the informal sector reaching to 52 per cent of the work force in 2003.<sup>42</sup>

To address this problem of coverage, a number of formal programs were created. For instance, a Fund for the Encouragement of Social Cooperation and Solidarity (now reorganized as a directorate) was established in 1986 to help fill the gaps of the insurance system by providing financial aid to help pay health expenses.<sup>43</sup> Another means-tested program, the Green Card scheme was created in 1992 similarly as a social assistance mechanism for poor citizens. However, it failed to provide support to many of the most needy who were not considered 'poor enough' to receive Green Cards. As a result, despite the expansion of formal insurance to cover the very poor, still 20 percent of the population (14 million people), mostly consisting of those working in the informal sector, is thought to have no coverage under any scheme.<sup>44</sup>

Apart from this problem of coverage, the social insurance system was increasingly criticized on the grounds that it reinforced hierarchies and inequalities among different occupational groups. Two developments should be highlighted to understand these criticisms.

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<sup>42</sup> At this point we have to indicate the problems with reliability of statistics in Turkey because different sources give different accounts of the number of uninsured: while the official statistics claim that it is around 20 per cent (which increases the number of insured to 80 per cent), the World Bank estimates the share of uninsured as around one third of the population (around 37 per cent). See World Bank, *Turkey: Joint Poverty Assessment Report, Vol I and II*. Report No. 29619-TU (Washington, DC and Ankara: World Bank and State Institute of Statistics, August 2005a), 72. On the other hand, Ministry of Labor's estimates go up to 52 percent. See CSGB (Çalışma ve Sosyal Güvenlik Bakanlığı - Ministry of Labor and Social Security). *Proposal for Reform in the Social Security System*, Draft Text. (Ankara: ÇSGB, 2004)

<sup>43</sup> The Fund for the Encouragement of Social Cooperation and Solidarity was established as an umbrella organization covering over 900 local foundations managed by representatives of the central government at the district level with the aid of a board of directors that included prominent members of the local population A. Buğra, "Poverty and Citizenship: An Overview of the Social-Policy Environment in Republican Turkey," *International Journal of Middle East Studies*, 39 (2007b): 46.

<sup>44</sup> *ibid.*

On the one hand, the end of national developmentalism and adoption of export-oriented industrialization model curtailed the political influence of the beneficiaries of the old welfare regime, that is the industrial workers and state employees, and by doing so it opened the way for a possibility of major reform of the social insurance system. On the other hand, the new economic policy expanded the number of people working in the informal economy who, by definition, were excluded from the formal social security system and therefore did not have a reason to resist any major change that would disrupt the status quo. These informal sector workers would, on the contrary, benefit from any attempt at dismantlement of the corporatist system and universalizing the coverage. These two factors explain why Justice and Development Party succeeded in his recent reform initiative to transform the social security system.

*What about the informal mechanisms? What happened to them during this major socio-economic transformation? Were they able to compensate for these growing problems in the formal sector or did they weaken considerably as well?* When we look closely at individual informal practices, we can see that while some of them preserved their role in terms of providing or facilitating access to health services, some mechanisms became almost totally unavailable. First, with changing incentives and payment methods in health care system, doctors and hospital administrators could no longer provide free health services to the needy. The new hospital payment methods implied that there would be no additional transfers to public hospitals during the year and thus they had to stay within their budgets. In addition to financial pressure, rising demand especially in urban areas as a consequence of rapid urbanization and failings of the primary care system deepened the crisis of public hospitals. Hospital administrators and staff began to evade from the uninsured patients, consequences of which could be seen in the newspapers of the time which talked about sick patients sent home,

uninsured patients traveling in ambulances from hospital to hospital in search of a facility which would admit them, patients held in pledge until their standing bills were paid, etc.

Second, the new practice of revolving funds meant that what doctors earned was dependent on the number of patients they treated. In this context providing free care remained uncompensated through any other source and doctors would be penalized with lower income if they continued to provide free care as the uninsured did not appear in the books. While this represents an important change in the incentive structure, our research indicated that individual doctors still tried to help to the uninsured by waving their own fees or by guiding them through the health insurance system. For instance, an interviewee described us how the head physician wrote a letter for the state agency dealing with handling of the Green Card applications, describing her health problems and confirming her need for this insurance. When they saw the letter, the interviewee said, the agency personnel facilitated the application process and she received her card within a few days. Other interviewees also mentioned how doctors, other hospital staff or pharmacists guided them through the insurance system; told them where to get free care, how to apply for public assistance for health, or informed them about new laws and regulations that provided new opportunities for accessing health services etc. Third, in the new economic environment, as indicated above, transfers from the central budget to the social security funds emerged as a major policy issue, especially in relations with the IMF which continuously warned that it was harming budgetary austerity. This again meant that the social security funds had to be more careful in what they pay for and hence should penalize fraudulent use of social security cards as they would not be compensated anymore for the services provided to the so-called ‘free-riders’.

The signs of this shift in the attitude of the health care staff as well as the fund administrators could be seen in the way interviewees responded to questions about social

security card use. While many of my interviewees admitted using someone else's social security card (usually it was Social Insurance Institution cards) mostly for buying prescription drugs, especially in the case of the Green Cards I noticed a real concern on the part of the cardholders. The latter were seriously worried that they would lose their right to hold a card if they allowed its use by an uninsured family member or friend and they told me how recently the state agencies began to regulate the issuing and the use of cards. Although many of the interviewees admitted committing these practices in the past (though some of them agreed to talk about this only after making sure that the tape was turned off and their names would not be mentioned in the article), they made it clear that it has become very risky now and they would never do such a thing as they are now faced with the real threat of losing their cards.

In sum, two of the informal mechanisms – borrowing other people's cards and asking for help from the hospital staff – were significantly weakened in the new market-friendly health care system. However, my research demonstrates that, in facilitating access to health services the role of family and community remains important. There is no doubt that in line with the weakening of the agricultural sector, financial and in kind transfers from the village have lost their importance. But, we should keep in mind that by the 2000s most members of large families have already migrated and now lived in İstanbul. Although it is true that nuclear family has become the norm in urban areas, some of the uninsured citizens interviewed indicated that they either share the same apartment or lived in the building owned by their in-laws, indicating the continuation of support from the larger family. The same interviewees also admitted that they received financial help from their families when they had to go to hospitals. Another interview mentioned how her father brought her elder sister who lived in a village in South East Turkey to deliver her baby in İstanbul. She delivered the baby and the father paid for the health expenses.

Second, as this example also demonstrates, inability to live in the same neighborhood of İstanbul or even at another city does not weaken the role of urban social networks or families in accessing health care services. Although the research did not focus on the Kurdish migrants who came to İstanbul after 1990, two of the families interviewed fit this description. Keeping in mind that it is hard to generalize for the whole Kurdish community who recently migrated, it must be noted that members of these two families did not complain about the weakening of urban social networks which were available to the first wave of migrants. Thus, unlike social assistance or housing, in health care families and acquaintances continued to serve an important safety net function by providing financial help or by facilitating access to doctors, especially if one of the network members worked in a hospital. One interesting finding with respect to facilitating access that was raised by an interviewee, however, was that, wider non-family social networks did only help the immediate members of the network but refrained from helping a network member's friend's mother in getting an appointment from a popular public hospital in İstanbul. In sum, although their parameters might have narrowed, social networks and family remain important actors in the welfare mix.

##### **5. Conclusion: Crisis of Corporatist-Informal System and Health Care Reform**

This paper aimed to analyze the transformation of the formal and informal pillars of the Turkish health care system as part of the wider transformation of the welfare system. It then set out to understand how this transformation in health care system contributed to the perceived need for reform. Before this final discussion on reform, it must be stated that this is a very preliminary analysis of the transformation and it is very difficult to establish causal links between the changes in the health care system and the motivations of the policymakers. But still, this research provides some initial ideas about the context in which reform took place.

First, with respect to the formal pillar, the paper argues that changes here have contributed to the opening up a 'window of opportunity' for reform: the effects of the shifts in the alliances among dominant forces in the Turkish welfare system have been seen in the weakening of the legitimate status and claims of formal sector workers and their unions which had been staunch opponents of national health insurance. Unlike previous Turkish governments which could not resist powerful opposition of the unions, the JDP publicly criticized unions and used every instance to de-legitimize their opposition to its reform proposal saying that the unions were only concerned with losing their privileges whereas the JDP was trying to universalize health insurance coverage. Furthermore, the large segments of the population who work in the informal sector and who happen to be JDP's constituency, did not have any stake in the continuation of the corporatist inegalitarian insurance regime. When the big business's new emphasis on universalism and need for reform of the social security system was added to this picture, a very hospitable environment for reform emerged which was effectively used by the JDP government.

Second, this paper identified various informal practices in health sector and traced their transformation as Turkey shifted its economic policy significantly towards market economy. It demonstrated that unlike other areas of the welfare regime, family and social networks continued to carry out important functions in health care in terms of providing financial help as well as facilitating access to health services. However, the role played by the health care staff in the informal security system has changed considerably in the late 1990s and early 2000s. While the research suggested that the physicians and other health care workers individually tried to help the uninsured as much as they could by waving their fees or guide them through the complexities of the system, incentive structures as well as the work environment in health sector have undergone major transformation. In the new economic environment where health care has been increasingly commodified and 'how much you

spend' on health care became a concern for social security funds, hospital administrators and health care workforce, the provision of 'free care' to the uninsured became increasingly problematic. On the one hand, new payment systems in hospitals encouraged physicians to think twice before providing free care as this would have a direct impact on their income. On the other hand, already being burdened with growing demand for secondary and tertiary care, public hospitals no longer had the resources to provide care for the uninsured which was not compensated by the insurance funds or the central government. Furthermore, as indicated in the reform agenda 'Health Transformation Project' (HTP) clearly, the Ministry of Health was seriously concerned with the inefficiencies and waste in health care system. Many elements in the agenda point to the awareness of the MoH to strengthen its 'regulation' function as well as improving the 'efficiency' of service provision such as 'giving institutions more administrative and financial autonomy'; supporting more rational use of drugs and medical devices through the establishment of a national drug agency and a medical device agency; and improving health information systems. Especially with the development of a system of electronic medical records, the reform aimed to improve collection of contributions while at the same time preventing 'fraud' which usually takes the form of use of someone else's social security card or benefiting from the Green Card scheme despite being financially well-off.

All these changes introduced in the health care system since the mid-1990s can be analyzed as part of a drive towards 'formalization' whereby the state institutional power engages with and expands to control the informal sector/practices. It must be noted that there is no major shift in the legal structure governing the health care system, and yet, the health care authorities, that is the Ministry of Health and social security fund administrations, no longer turned a blind-eye on informal practices and began to detect and prevent these "fraudulent" practices. This represents a major change in the interaction of the formal authority with the informal sector which must be examined more closely in future work on

Turkish welfare system. Leaving this discussion for future papers, I now turn to address the question of how such transformation of the informal pillar plays into the reform game.

Although ‘access to health care’ does not appear to be an issue of priority for many Turkish citizens, it has been carried onto the public agenda as part of the wider concern with ‘rising poverty’ in the aftermath of the economic crises of the early 2000s. JDP’s interest in health care reform should be analyzed as part of this concern with growing threat of social dislocation as part of the rising poverty.

The first signs of a new policy approach to poverty were evident during the election campaign of 2002 where the JDP leader Recep Tayyip Erdoğan promised a ‘caring’ government to an electorate which was fed up with growing poverty, distorted income distribution and economic inequality. At this point, considering the ideological inclinations of the party, it is possible to make two arguments: one, the conservative liberal outlook which draws on the Islamic principles, may explain to some extent, the sensitivity of the party towards the worsening condition of the poor. Furthermore, some of the political leaders in the governing party, including the Prime Minister Erdoğan himself, frequently refer to their own socioeconomic background and their personal experiences with poverty, which, they claim, oblige them to adopt a distinctive approach to poverty and take action to alleviate the condition of the poor. Universalizing health insurance and thus solving problems of access can be seen as a step in this direction. Second, when we consider the constituency of the JDP, we can see that it gets most of its votes from those people who have recently migrated to the cities and who have limited means of securing their livelihood. Universal health insurance is a way to satisfy the growing needs for security of these segments of the population and thus deliver its promises of a ‘caring’ government.

Adopting a Polanyian framework, it is possible to explain the HTP’s universalizing attempt and bringing about a caring government in terms of ‘embedding’ the markets or

‘maintaining the social cohesion’. Recognizing that the policymakers, in this case including the bureaucracy and the political elite, have a longer-term view than particular groups in society, we may argue that they deem universalizing health reform as a necessary measure to protect society from market. In an environment marked with deep and frequent economic crises, rising unemployment and expanding informal sector, the weakening of some of the informal mechanisms might significantly deepen the problem of access for a growing number of Turkish citizens. The ‘universalizing’ elements in the reform program, such as the establishment of a single fund which covers the entire population, provision of all health services to the children under 18 free of charge, offering primary care services to the entire population free of charge (introduced immediately before the 2007 general elections), expanding the coverage of the Green Card scheme to cover prescription drugs as well as outpatient services, can be interpreted as a response to the grave situation of the poor and the uninsured. But these elements also contribute to the vitality of capitalism as the reaction of society is preemptively averted and social peace is secured. Last, but not least, universalism can be interpreted as a means for the markets to expand into service sectors which have until recently been the domain of the public sector. Universal rights to education, health and social protection are considered in this framework as essential to economic growth as well.

This argument which puts forward structural-functionalist reasons for JDP’s involvement in health reform sheds some light on to the contemporary policy developments in health care. Yet, it must be noted that it is quite limited in accounting for the international dimension of policymaking. To reach a more complete understanding of the reform dynamics we need to complement this with a historical-institutionalist analysis that traces the changes in the balance of power among major domestic policy actors and examines their interaction with global policy circles.

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**Table 1- Population coverage (Health Insurance and Green Card) 2000**

<b>Program</b>	<b>Numbers Covered</b>	<b>% of Population Nüfus (%)</b>
<b>SSK</b>	<b>34,141,000</b>	<b>51.5</b>
Compulsory	5,284,000	8.0
Voluntary	1,029,000	1.6
Pensioners	3,340,000	5.0
Dependents	24,488,000	36.9
<b>Bag-Kur</b>	<b>15,036,000</b>	<b>22.7</b>
Compulsory	2,173,000	3.3
Voluntary	1,140,000	1.7
Pensioners	1,277,000	1.9
Dependents	10,446,000	15.8
<b>ES</b>	<b>9,766,000</b>	<b>14.7</b>
Active workers*	2,164,000	3.3
Dependents*	6,305,000	9.5
Pensioners	1,297,000	2.0
<b>Special Insurance Funds</b>	<b>270,000</b>	<b>0.4</b>
Active workers	78,000	0.4
Pensioners	71,000	0.1
Dependents	121,000	0.2
<b>Total Covered by Insurance</b>	<b>59,213,000</b>	<b>89.3</b>
<b>Green Card**</b>	<b>10,125,706</b>	<b>15.3</b>
<b>Insurance or Green Card</b>	<b>69,338,706</b>	<b>104.6</b>

(\*) Active government workers and their dependents are not directly covered by an insurance program; rather the Ministry of Finance reimburses the respective ministries for the health care costs of their

(\*\*) These figures do not reflect the fact that more than 1 million Green Card recipients have recently been removed from the registers following efforts to verify eligibility and remove duplicate cards.

Source: TÜSİAD, Charting the Way Forward: Health Care Reform in Turkey, 2005.

**Table 2- Membership in Social Security Institutions, 2003**

Membership status	Number of workers	Percent
<b>Registered</b>	<b>10,205,000</b>	<b>48.3</b>
<i>Social Security Institution (SSK)</i>	<i>5,551,000</i>	<i>26.2</i>
<i>Retirement Fund (ES)</i>	<i>2,177,000</i>	<i>10.3</i>
<i>Bag Kur</i>	<i>2,455,000</i>	<i>11.6</i>
Private institutions	22,000	0.1
<b>Not registered</b>	<b>10,944,000</b>	<b>51.7</b>
Total employed workforce	21,149,000	100.0

*Source: World Bank, 2005*

**Table 3 -Informal employment in manufacturing and service sectors in Turkey**

	<b>Total economy</b>	<b>Agriculture, forestry hunting and fishing</b>	<b>Manufacturing</b>	<b>Construction</b>	<b>Wholesale and retail trade, restaurants and hotels</b>	<b>Transportat and storage</b>	<b>Finance, insurance, real estate and business service</b>
1988	58.1	93.5	23.9	56.2	37.5	34.5	9.8
1989	58.7	92.2	26.3	56.7	39.2	34.9	8.4
1990	55.6	90.3	23.5	52.8	34.5	28.4	8.1
1991	51.2	79.8	24.5	59.2	32.5	21.6	6.6
1992	49.2	78.8	27.1	55.6	32.1	19.5	8.2
1993	47.5	78.0	24.5	52.2	31.5	19.7	9.3
1994	45.7	70.2	27.3	55.2	47.5	19.7	9.9
1995	49.2	78.0	25.2	57.8	34.3	22.6	9.3
1996	52.7	88.4	23.0	58.0	31.5	20.0	11.3
1997	51.6	89.2	21.6	60.8	30.3	23.6	8.9
1998	50.3	88.5	20.7	53.1	29.0	25.5	8.0
1999	52.1	89.3	25.6	60.4	33.1	29.8	10.4
2000	50.6	88.6	26.4	65.5	37.1	31.4	13.8
2001	52.9	91.8	27.2	61.7	39.5	33.1	16.2
2002	52.1	90.2	31.7	61.5	42.7	34.0	18.9
2003	51.7	91.2	30.7	63.8	42.2	33.9	20.1
2004	53.0	90.0	31.3	66.5	44.4	38.8	20.6
2005	50.1	88.2	32.0	64.3	43.8	39.0	21.6