

*Turkish Health Care Reform in the Era of Pax Americana:
The Interplay of Social Class, the State and International
Institutions*

By

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The neoliberal winds of change began influencing Turkey in the late 1970s when Turkish governments had to negotiate a comprehensive restructuring of the Turkish State with the notorious 1979 IMF Standby agreement. (Ramazanoglu, 1985) The subsequent 1980 Austerity Measures, despite the overwhelming support of the Turkish bourgeoisie's dominant factions and the military, failed to alleviate the crisis, on the contrary, the program exacerbated the increasing tensions between local manufacturing based Turkish bourgeoisie and the Istanbul industrial and financial capitalists. (Kongar, 2002)

In face of the State's incapability of organizing the hegemonic power bloc behind the brand new neoliberal agenda, the military intervened and launched a neoliberal conversion process that attempted to retrench the State thoroughly on the basis of an export-led growth model. (Keyder, 2004) The neoliberal experience *a la Turca*, hence, kicked off in the heydays of the Cold War by the early 1980s (given the global scale of upheaval in the international system including the Russian occupation in Afghanistan and the Islamic Revolution in Iran), thanks to the support granted by the United States Administration at the time, directly and indirectly via the IMF and the World Bank.

The following two decades in Turkey have witnessed an abrupt shift from the deficient import substitution industrialization programs to the export-led growth models, embedded against a liberalization and deregulation of the economy coupled with the reduction of tariffs and a financial liberalization. (Kumcu, 2001) Social service delivery restructuring, unlike the other macro-economic reforms, was subjugated to a prolonged process of delay. In such respect, this work attempts (a) to problematize the dynamics, i.e. the Turkish State and social classes, behind health care restructuring in relation to the delay that the project embedded against a context of American imperialism over the country (b) to locate the neoliberal retrenchment within Turkish health care with emphasis on the delay throughout the 1980s and the 1990s and (c) to locate Turkish political Islam that has eventually claimed to bear the unfinished project of Turkish liberalism that has been in effect since the mid-1980s.

Theoretical Considerations

In pursuing answers to understanding Turkish health care reform, the present work incorporates a Poulantzasian understanding of the capitalist state. In such respect, the state is relational, rather than being an institution of power controlled by the capitalist classes. The state is not to be problematized as an institution of power, rather as a relation between classes and class forces. (Poulantzas, 1969) The class struggle constitutes the determinant of the operations of the state, which is in fact internal but not external to the societal dynamics. (Levine, 2002) From this perspective, the bureaucracy is located within the class contradictions. The state, according to Poulantzas, by virtue of its relative autonomy

from the dominant classes, is wrought with the contradictions of the mode of production, itself. (Tabak, 1999)

Given the basic postulate in regard to the nature of the capitalist State, my proposition is that Turkish capitalist development, unlike a wide variety of studies on Turkey, does not correspond to a pattern of a simple instrumentalist reading of the State as an object, in which historically, the big landowners and the comprador bourgeoisie coalesce to grasp the state power to pursue their interests. In light of the weaknesses of the Turkish working classes within Turkish political economy development until the mid-1960s, the recent four decades of Turkish capitalism can be very well characterized by growing class struggle and contradictions.

As for the question of the capitalist class within the class-profile of modern capitalist society and in contrast to the stereotypical conception of the capitalist class as a monolithic homogenous united class, the capitalists are internally divided, for the units of capital are in constant competition with one another. (Poulantzas, 1973) In this sense, the division of capital into competing units of accumulation has been a quintessential element of the capital accumulation process thanks to their isolation and working one against another. (Levine, 2002) The Turkish case of capitalist development, indeed, demonstrates a *par excellence* case of the vast divisions within the Turkish capitalists. Since the early years of the Republic, the Istanbul-based financial and industrial capitalists and the burgeoning capitalist groups of big-landowners in Asia Minor over years, have two constituted the two different axes of the Turkish Capitalists.¹ (Atasoy, 2000 and Keyder, 2004)

What does the Poulantzasian theory of the capitalist have to offer, if at all, at the policy level to guide us within the analysis of the Turkish health care reform? The class contradictions and class conflicts that arise from the nature of the capitalist accumulation process are embedded against the structure of the state and, as such, provide structural limits and boundaries to state activity.² Given the relative autonomy of the state from any class or class fraction, state policy is capable of mediating between conflicting fractions of the capitalist class and channeling working class discontent with the overall accumulation of capital. The precise manner by which the state mediates the balance of class forces depends on the balance of class forces represented throughout the state. (Mahon, 1977)

The Turkish State's neoliberal retrenchment process, then, becomes a complex phenomenon, which begs the question of the representation of different classes within the Turkish State. In this manner, the conventional sections of Turkish capital groups i.e. the Istanbul-based industrial and financial capital groups have claimed to be the 'promised ones' within the traditional model of Turkish capitalist development.³ Nevertheless, the Asia-Minor agricultural and manufacturing bourgeoisie have always countervailed the impact of the dominant sections of Turkish capital throughout different phases of the Turkish Republican political economy development.

From the perspective drawn above on the nature of the Turkish State, I would now like to turn to the welfare state development and the subsequent restructuring at a more general level in the so-called ‘developing’ world. The literature on the welfare state has traditionally tended to focus on cases from the West. Accordingly, the term ‘welfare state’ has been treated as a unique construction of the linear socio-economic development in Western Europe and the restructuring process has been shaped by the *sui generis* circumstances of the Western world. Yet the non-Western world experienced the superimposition of welfare state institutions in the post-1960s and, more recently, has been subjected to the restructuring process.

The origins of the Turkish welfare state can be traced back to the early years of the republic as the witnessed the emergence of occupational welfare group-based one which was exclusively defined for the government officers and the military personnel at primary stages.⁴ (though formalized under the name of the Pension Fund in 1952.) As early as the 1940s, the Turkish State intervened into the socio-economic realm by replicating the similar, yet more inferior social security mechanism for the newly-emerging working classes that were yet far away from being a social dynamic at the time (the Social Insurance Institution). Over time, *Bag-Kur*, the third jurisdiction of social security was again replicated for the urban and rural subordinate classes by 1972 thanks to a strengthening working class throughout the country. The common dynamic behind the development of such a stratified occupational welfare group-based system was, again referring to the Poulantzian understanding of the State, the changing power blocs and their corresponding capacity to influence different policies within their representation in the Turkish State in different modes of capitalist development. In this general picture, the Turkish health care system also developed on the basis of occupational welfare groups for whom state-financed and operated public hospitals provided basic health care services. The system was financed through the contributions of public security mechanisms and the state itself. By the late 1970s, the health care system came to be a rather extensive one with entangled jurisdictions for specific welfare groups. Despite the extended coverage within the health care system via public agents, a well-endowed private health care system flourished with its public counterpart from the late 1960s on.

The Turkish neoliberal-mania in regard to the restructuring of the State began in the early 1980s, like her western counterparts. However, what really differentiated the process in the non-Western welfare states, including the Turkish welfare state was that the caretakers of the global order – the IMF and the World Bank- were more than involved in the course of restructuring than they were in the West. Ultimately, the very process of restructuring has become one of the media through which Pax Americana has penetrated the non-Western world and facilitated the reorganization of such states to meet the demands of the imperial hierarchy. As such, the basic requirement of the American imperialism dictated that the appropriate and acceptable form of the unit of state for the international system was the neoliberal state. As Poulantzas indicated by the mid-70s, the new form of

imperialism, by virtue of the internationalization of the capital in terms of the changing nature of the power bloc, brought about ‘the internalized transformations of the state itself.’ (Albo, 2004) In such respect, in addition to this internalized transformation, the social form and organization that the State assumes, changes in relation to the internationalization of capital. In the midst of such a transformation, writes Albo,

Internal economic policy apparatuses will become increasingly subordinate to those dealing with the internationalization of capital, particularly to ensure the stability of the currency and its role in international circulation. Thus the entire state will be conditioned by international competition. (Albo, 2004)

The state, Panitch indicates, is charged with one more mediation function, in neoimperial times, that is of international accumulation by the state. (Panitch, 2000) Thus, at this very point, the location of any particular state within the international capitalist system matters insofar as *“the capacities of each state to mediate international competition are determined by its administrative and diplomatic capacities, in the imperialist chain and internal class divisions.”* (Albo, 2004)

In the case of Turkish health care reform, two important parameters have been influential in the making of the process. First, the Turkish State as an equilibrium of unequal class and intraclass relations was quite problematic vis a vis the internationalization of capital. By the late 1970s, as a matter of hegemonic function, the state has been able, though less than easily, to organize the power bloc behind the neoliberal retrenchment process which health care reform has been an integral part.

Nevertheless, cognizant of the overwhelming resistance of subordinate classes and other discontenting Turkish capitalist factions (Asia Minor manufacturing bourgeoisie and other lower middle classes that are inclusive of independent farmers, public employees and other sections of the petty bourgeoisie) on the model of export-led growth model, the power bloc supported and more than welcomed the 1980 military coup that set the stage to the neoliberal conversion. In the years to come, on behalf of state capacity to moderate the resistance versus the neoliberal revolution in Turkey, the state had insurmountable difficulties in maintaining the power bloc behind Turkish health care reform intact. Secondly, the geopolitics of Turkey granted an important, albeit restricted, maneuver capability against the imposition of American interest within the Middle East Region as a regional outpost. In this regard, I propose that the geopolitical advantage of Turkey has significantly worked against the global neoliberal transformation project, as an imperial imperative in the developing world. By virtue of such an advantage which countries including Argentina and Brazil were not privileged to enjoy, the Turkish State slowed down the pace of the neoliberal retrenchment process which health care reform was a quintessential part, despite the fact that a comprehensive process of recommodification within the health care system and assaults on public health care worker unions were on the way as early as the 1980s . (Belek and Soyer, 1998)

Locating the Dynamics within the Turkish Health Care Reform and Accounting the Delay in the Process

The Late 1970s Crisis: The demise of the pre-neoliberal power bloc

Turkish capitalism suffered from a chronic balance of payments crisis and overwhelming social unrest within the society by the end of 1970s. (Keyder, 1987 and Atasoy, 2000) The previous developmental model based on ISI failed to produce the results desired by the Turkish bourgeoisie and the Turkish State apparatuses. This project, in terms of its strategies, divided the ruling class coalition or the power bloc into two camps: industrialist groups of the bourgeoisie who were involved in the foreign trade and montage industry and the small-size industrialists who were engaged in the domestic market. (Atasoy, 2000) By the mid 1970s, the larger industrialists opted for a more open trade regime in contrast to the middle level of industrialists who preferred government protection. Thus, there were different factions within the bourgeoisie that clashed with each other in terms of their economic interests. In addition, the consensus among the capital and the subordinate classes in the 1960s behind the formal basis of Turkish welfare state was less than sustained anymore.

The military intervened with the 1980 coup as a result of the state's incapability of organizing the hegemonic bloc among the Turkish capitalists. The bureaucratic cadres led by the military, via which industrial capitalists were represented, instituted a new regime of growth that would alleviate the economic crisis, restore the 'civil' order and capital accumulation; and repress the Turkish working class by the same token. In this regard, the 1980 military takeover has become a landmark event in Turkish political-economy setting since it prepared the foundations for the ruling classes' consensus for the post 1980s socio-economic agenda. The military take-over in this sense aligned the post-1980s political economy setting in favor of the larger industrialists and "*the subsequent civilian governments subordinated small and medium size industrial fractions of capital, rural populations, and labor within the neoliberal agenda.*" (Atasoy, 2000)

The post-1980s Formation and Development of the new power-bloc

The power bloc that was consistent of the financial and industrial bourgeoisie, and thanks to their overwhelming representation through the executive bureaucracy and the military, gained more significance and influence in the neo-liberal transformation project of the 1980s. The working classes and other sections of subordinate classes were no longer welcomed in the post-1980s new neoliberal equilibrium. In such respect, the post-1980s economic agenda served to disorganize the working classes and the deprived sections of the society through a comprehensive process of de-politicization. (Belek and Soyer 1995) In addition to the working classes, the peasantry and the rural-based groups and the rise of Islamic fundamentalist movements (although at a discourse level) formed the other support bases of resistance to the neoliberal model.

The successive civilian governments throughout the 1980s, however, also contributed to an overall consensus-building among the urban-based middle classes and the medium and small-sized industrialists around the notion of market-oriented economic policy. (Atasoy, 2000) The neo-liberal agenda targeted radical changes in Turkey. In this respect, observes Bayar:

The year 1980 was the beginning of the radical transformation of Turkey's political economy from its ISI orientation to a more open system. Reform of the trade regime was the core of the programme. The first element of the reform was the devaluation of the TL and a commitment to a flexible exchange rate policy. The second element was the promotion of exports through tax rebates, export credits, and other subsidies. The third element of the trade reform was import liberalization. The import regime was changed radically at the end of 1983 with the announcement that any item other than those specifically banned or subject to licensing could be imported freely. Quantitative restrictions were removed and tariffs were lowered from an average of 19% to 12%. (Bayar, 1996)

Health Care Reform, the New Power Bloc and Pax Americana

The Turkish industrial capitalists advised the governments from the end of 1970s that a social service reform should be carried out since public provision of the services was being too costly for the system to bear with. They also encouraged that Turkey should turn an ear to the recommendations of the global financial institutions like IMF and World Bank. Turkish capitalists, especially the large industrialist groups of the bourgeoisie, were very well aware that a restructuring of social services would open new opportunities for their capital accumulation, since the health care sector would be a very large market worth of millions of dollars annually. (Belek and Soyer, 1998) The executive bureaucracy, via whom the industrial capital had substantial representation, prepared a major blueprint for a comprehensive health care reform at many instances with the help of the World Bank and private international consultancy companies. The Turkish capitalists also hoped that social services restructuring, in particular within health care, would further curb the strength of Turkish working classes who were already hampered by the junta government in the 1980s.

The military coup administration designed the legal framework of the post-1980s agenda such that the 1982 constitution, prepared under the auspices of the junta government, abolished basic socio-economic rights like the right to collective bargaining and the right to strike while it did not consider the right to health care as a socio-economic right at all. (Ardic, Belek et al, 1992) The provisions of the new Constitution subscribed to the view of setting up private life insurance system, which did not necessarily have to be public. (Belek, 1998) The military and the subsequent neoliberal Motherland Part governments along with the 'imported' new executive American educated and trained executive bureaucracy targeted to squeeze and confine the zone of movement of the working classes and millions of unemployed in Turkey. (Belek, 1998) The civilian governments inserted health care restructuring into their programs and passed the legislations that would enable

them to carry out the restructuring throughout the industries.⁵ (Belek and Soyer, 1995)
Yet, public health care restructuring confronted vigilant opposition and resistance within the Turkish State and other subordinate classes.

The question then simply becomes; why were the civilian governments, despite their ambition, less than capable of carrying out public health care restructuring? In posing an answer to the very basic question, I now will turn to those domestic factors:

Domestic Dynamics

Several domestic political dynamics have been influential in delaying the health care restructuring process. It is important to note that these domestic political dynamics have been excluded out of the new right agenda. Most of these groups went through such an ardent process of de-politicization and disorganization that they could not articulate their interests via formal channels within the status-quo. The first set of political dynamics are the working classes and the subordinate classes who were predominantly the unemployed people in the metropolitan cities.

Although the military coup in 1980 struck the working classes movement deeply, they still maintained a major basis of political support for party politics. The idea that a restructured public health care system would diminish the support for the mainstream political parties and would lead to the unemployment of a substantial number of health care workers who were unionized under state-recognized public unions, made them reluctant in terms of initiating the public health care restructuring. (Belek and Soyer, 1995)

Moreover, the civilian governments were reluctant in following a policy of health care restructuring that would polarize the working classes *vis á vis* the new-market oriented neoliberal agenda. Given the strength of the working classes in Turkey during the 1960s and the 1970s, the neo-liberal agenda pro-governments, as a matter of social maintenance, did not desire to see an opposition force against the new order

Secondly, I will turn to the Turkish peasantry and rural-based groups who were within the disorganized masses in the post-1980s. In fact, the peasantry in Turkey has been a strong advocate of political parties pursuing populist policies that they could make use of, in the short run. The political parties, which ambitiously pursued the new right agenda in the post-1980s, paradoxically relied heavily on the peasantry and other urban based groups for their popular support. The loss of such support from these subordinate classes, by means of public health care restructuring, meant much for the mainstream political parties. In fact, the industrial and financial bourgeoisie criticized the governments, in that, governments were not realizing that Turkey was no more an agricultural society. However, the party politics in this sense, rather than losing the total support of the peasantry and others in question, played in favor of these groups and classes until the mid-1990s. In line with such a motivation, governments through 1990s extended the welfare

regime to those underclasses and the disabled population by means of the Social Assistance and Solidarity Fund and even provided free health care services to these particular groups by the 'Green Card' scheme. (Ilker and Belek, 1995)

Thirdly, the Islamic fundamentalists were one group within the domestic dynamics that delayed the restructuring in the public health care sector. The fundamentalist Islamic movement was an extreme polarized component of the party politics in the 1970s. There were two differences in terms of political Islam in the 1980s. One is that the military government in the early 1980s and the subsequent civilian governments preferred to create a nationalist and Islamic discourse to handle the masses that were to be depoliticized and to gain their support by means of such a discourse. (Kongar, 2002) Such an ideological propagation on behalf of the State can be located in the US project of the 'Islamic Green Belt' versus the Soviet Bloc. However, the peasantry, the unemployed in the big cities and the lower middle classes were already disillusioned by the social implications of the neo-liberal agenda. Meanwhile, the Islam-based political parties in Turkey focused on and promised the protection of small capital movements, labor from the negative effects of the market economy. (Onis, 2001) However, political Islam more than willing to integrate with the international capitalist system, yet, they emphasized on the need to buttress the social aspect of the neoliberal agenda. In this regard, the disorganized subordinate classes especially in the metropolitan sectors were mobilized by the Islamist parties in the post-1980s settings of Turkey.

According to the post-1980s governments, health care restructuring would be likely to limit the scope of services that these groups were making use of. The governments were also cognizant that the shift of the political support of these classes to fundamental Islamists would supposedly 'destabilize the secularist regime' and the economic program put into application after the 1980s. Secondly, the newly emerging capital groups in Anatolia, was also of high significance for civilian governments of the 1980s. These newly emerging capital groups were disillusioned by the post-1980s partial consensus on the neoliberal project. Nevertheless, they adapted themselves into the neo-liberal economic agenda, by small and medium-scale industries in Anatolia thanks to the Saudi capital that poured into the country throughout the 1980s. In the next decade, most of the small and local capitalist groups were to advocate political Islam with every means.

Pax Americana, International Institutions and Health Care Reform:

The neoliberal transformation of the State in the world capitalist system has also affected Turkey in a new era of Pax Americana in the 1980s. However, this was in no way a unilateral dynamic in the case of Turkey. Since 1978 Turkey has been subjected to numerous stand-by agreements of the IMF. In all cases, Turkey was required to transform itself in the light of the neo-liberal prerequisites. The changes were evident in the economic transformation of the country but there was a considerable inertia regarding health care reform like most other social service delivery reforms. A mounting number of

legislations such as the Law 3353 and a master project of health care restructuring prepared under the auspices of the World Bank have not yielded the desired results in the social service delivery including education and health care. (Belek and Soyer, 1995)

Pax Americana has given Turkey the special status of regional outpost within the imperial chain. This particular role has granted Turkey the power to countervail neoliberal reforms with less extensive structural change in particular in the health care sector. By means of such a status that Turkey enjoyed, she could delay the making and the application of essential transformation that would complement the neo-liberal restructuring.

Restructuring of the Public Health Sector in perspective: 1980-2000

In this section, I will identify the concrete restructuring in the Turkish public health care sector. The Turkish experience has been that the structuring did not change the basic health care providers in Turkey. Basically, the Pension Fund (PF) with the State Hospitals, University Hospitals, State Economic Enterprises Hospitals, the Social Insurance Institution (SII) with its own hospitals, the Bag-Kur via the State hospitals remained in the system. Rather, the changes were internal changes in the providers' funding and investment tendencies along with the development and nourishment of the private health care sector. The changes will be analyzed in three dimensions at the funding, investment/structural changes, and expansion of private health care market. Before accounting for changes, it will be necessary to outline the Turkish social security organizations with the main health care service providers.

In terms of the financers of the public health care system, the social safety nets were organized into a tripartite system, namely the Pension Fund, the Social Insurance Institution and the Bag-Kur. In terms of the health care providers, the Pension Fund financed publicly-funded and central-government-operated or autonomous agency-operated hospitals such as State Hospitals, University Hospitals, State Economic Enterprises' Hospitals and Municipalities' Hospitals for the bureaucrats, government employees and military personnel. The second tier of the social safety net covered the working classes in the public and the private sectors, the contractual intermediary classes in the private sectors, and public sector workers under the Social Insurance Institution, which came to operate and finance its own hospitals and became the second largest health care service provider and financer throughout the country by the late 1970's. (Eren and Tanritanir, 1998)

The third tier of social safety nets as a health care service financer became the *Bag-Kur* Fund in 1972, which served the lower middle classes (local merchants and the independently working artisans) and unorganized laboring classes (the farmers and the peasantry), with the meager and limited health care services provided by the state hospitals or the university hospitals imposing co-payments on the patients.

In this respect, the schema below summarizes the tripartite Turkish public health care system in terms of the financing bodies, the basic providers and the coverage of the health care system between 1960 and 1980:

Table 3.3 The Tri-Partite System of the Turkish Public Health care Sector by the late 1970s:

Health care Financing Bodies: BASIC STATE INSURANCE FUNDING SOCIAL SAFETY NET AS FINANCERS The Pension Fund (PF) The Social Insurance Institution (SII) The Bag-Kur	Health care Providers Under the general jurisdiction of the Ministry of Health: The Ministry of Health Hospitals i.e. State Hospitals, Under the general jurisdiction of the High Board of Education, and the Universities i.e. University Hospitals, Under the general jurisdiction of the Ministry of National Defense: The Ministry of Defense Hospitals (exclusively for military personnel), Under the general jurisdiction of the regarding Ministries: the State Economic Enterprises' Hospitals, Under the general jurisdiction of the Municipalities: Municipalities' Hospitals SII Hospitals Ministry of Health Hospitals i.e. State Hospitals and University Hospitals, on a limited basis	Beneficiaries of the Coverage Guaranteed by Health care Financing Bodies Civil servants, local government personnel, government personnel, military personnel, university teaching and academic personnel through compulsory contributions to the PF deduced from their monthly salaries. The working classes in the public and the private sectors, the contractual intermediary classes in private sectors through compulsory independent contributions to the SII Hospitals. Farmers, the peasantry, independently working artisans, the merchants through voluntary contributions.

With regards to the basic financers of the Turkish health care system, the State assumed a public insurance mechanism such that the occupational welfare groups' earnings were deduced by the relevant social safety organizations such as the PF, the SII and the *Bag-Kur*. The central government also distributed funds to the PF, the SII and the Bag-Kur via the Ministry of Health. Those essentially act as intermediary agents that purchase basic

health care services from public health care service providers for their beneficiaries. (Eren and Tanritanir, 1998)

Government officers, military personnel, contractual government personnel, local government employees paid for their compulsory contributions to the PF with higher rates, meanwhile the workers employed in the public and the private sector and the contractual intermediary classes in the private sectors and public sector workers contributed to the SII with lower rates again on an compulsory basis.

The *Bag-Kur* social safety net however had a voluntary base of participation for those from the lower middle classes, farmers and the unorganized working classes, with the least contribution system on a voluntary basis in the public insurance system. (Eren and Tanritanir, 1998)

Health care Financers

The public health care sector had a wide array of health care providers financed by a central budget of expenditures and contributions through the state insurance funds.⁶ The Ministry of Health hospitals were located at the top of the system. State hospitals, State Economic Enterprises' (SEE) Hospitals, the Municipalities' Hospitals were located under the financial and administrative jurisdiction of the Ministry of Health. The ministry financed and administered these hospitals.

As for the financing of the SEE's hospitals and the Municipalities' Hospitals, it was granted to the relevant agencies that had the jurisdiction over these bodies, via either the related ministry or the related local government. University hospitals and Military hospitals, meanwhile, became autonomously operating providers, that is to say, the universities' administrations and the military forces' have an administrative jurisdiction over their bodies. As for their financing, the Ministry of Health granted the necessary funding for the providers via the Higher Board of Education for the university hospitals and via the Ministry of National Defense for military hospitals. (Eren and Tanritanir, 1998) The only exception in this general setting were the SII hospitals that exclusively provided services for the SII beneficiaries, funded by their contributions, in addition to the central funding submitted by the Ministry of Health. State Hospitals and university hospitals provide services for both the PF and the *Bag-Kur* (except on a very limited basis in the case of the *Bag-Kur*). It is important to bear in mind that all health care service providers and financers were designed as non-profit publicly-funded organizations whose financing is shared between the tri-partite state insurance system and the central government budget. (Eren and Tanritanir, 1998)

Changes Regarding the Funding of the System

In the first stage, I will locate those structural changes in the public health care sector in the last twenty years of Turkey that have to do with the financing and funding system of the health care sector. The first set of changes is related to restricted public health care services in terms of volume; availability and quality from the mid-80s on by governments. (Belek and Soyer, 1995) This aimed to manipulate society to substitute these services with privately-produced and purchased substitutes with public funding. The changes in the financing and funding of the system are essentially important since they depict what kind of dual structuring has been brought about in the post-1980 at the public health care service providers level, the latter being State Hospitals for the PF, SII hospitals, Bag-Kur hospitals.

Between 1980 and 1992 the public health care expenditures rose relatively due to the fact that many providers of the public health care sector and the social safety nets started charging their beneficiaries higher rates for the net, co-payments and user fees. (Belek and Soyer, 1998) At the individual level, people were required to pay high user fees to make use of the health care facilities of the basic providers and they were asked to contribute with higher level of co-payments for medical supplies. (Belek, Nalcaci et al,1992)

In this regard, the basic observations regarding the funding of the system can be summarized below:

- 1.** The public health care sector witnessed an increase in private health care expenditures between 1981 and 1987 while the system confronted an increase in public health care expenditures from 1988 to 1992. (Tokat, 1993) The consolidated budget share of the Ministry of Health drastically went on falling from 4.35% in 1980 to 2.63% by the end of 1990s. This share started rising between 1990 and 1994 up to 4.51% in 1994. (Belek and Soyer, 1995)

- 2.** The revolving fund system, RFS, (*Doner Sermaye Sistemi*), which denotes the private sub-branch of public hospitals of the Ministry of Health where people were charged for health care services, became a formal mechanism for the fund-raising in more than 321 hospitals (that constituted 58.6 of all Ministry of Health Hospitals) of 634 Ministry of Health Hospitals by 1988. (which, this time was inclusive of 70.2% of all public health care hospitals) (Yildirim, 1994) The number of hospitals using RFS became 479 in 1996.(Belek and Soyer, 1998) The RFS in the public health care hospitals increased the total number of patient beds from 62598 (91.7 %of the total patient bed capacity) in 1988 to 74107 (94.6% of the total patient bed capacity) in 1996. (Belek and Soyer, 1998) The revolving fund mechanism generated 14.2% of the whole funding of the expenditures for the public hospitals. This percentage constituted a 12% of the funding for the public hospitals by 1991. The earnings generated by the revolving funds of public hospitals skyrocketed from 117 billions TL in 1988 to 1.5 trillions TL in 1996. (Belek and Soyer, 1998)

3. Looking at the SII funding, the SII basically got no funding from the Ministry of Health budget between 1980 and 2000. However, due to the increase in the number of the population covered by SII and due to the increase of the co-payments that workers had to pay to the safety net, the earnings of SII increased sharply from 31 billions TL in 1989 to 202 billions TL in 1992. (Tokat, 1993)

4. University hospitals also increased their funding by means of the revolving funds where the revenue budget share of the revolving funds' earnings in university hospitals reached 47% of the total budgets of university hospitals in 1991. (Yildirim, 1994)

5. The public employees covered in the PF also had to contribute with higher rates of co-payments for their prescriptions for the medication, medical equipment, and the dental care as high as 20% of the cost of these services.(Yildirim , 1994)

Health care Investment and Structural Change in the Health Care Sector.

Not surprisingly enough, the investment figures in Turkey's public health care sector started increasing for those investments done in the private health care market development. The health care investment figures for the private contracts that SII hospitals and Bag-Kur related Hospitals in exchange of the basic medical supply and medical treatment increased substantially. (Belek and Soyer, 1995) In the mean time, the investment for the public health care infrastructure and personnel plummeted drastically, while maintaining the investment for the private sector at very high rates. (Belek, Nalcaci et al, 1992)

The basic changes in terms of health care investment and structural adjustment may be juxtaposed as follows:

1. The investment figures in the health care sector ended up in not being able to meet the growing demand by the population. Governments consciously decreased the supply of services, which created a gap to be filled by the private health care market. The investment expenditures in Turkish public health care providers by the Ministry of Health were around 12.3% and 17.6 % between 1980 and 1990, where the percentage decreased to 7.7% in 1994. The SII health care providers increased their investment expenditures from 0.7 % in 1980 to 7.7% in 1986. This rate regressed back to 4.5% in 1992. Relatively speaking, total public health care investment expenditures fell from 90.3% in 1980 to 65.5% in 1992. (Yildirim, 1994)

2. The conditions of public health care personnel in Turkey between 1980 and 1990 in terms of compensation and wages drastically deteriorated. The wages of public health care sector specialist doctors fell from \$ 1223US to \$ 240US monthly in 1983. (Soyer, 1993)The wages for the specialist doctors started rising after the strikes of 1989. (Soyer, 1993) The number incredibly rose to \$ 1152 US in 1992 and then took a drastic deep to \$376 US monthly in 1994. (Belek and Soyer, 1995)

3. Turkish governments starting from the early 1980s on began to give overwhelming subsidies to the private health care market. The subsidies were granted to the private market in different forms such as their exemption from customs taxes, cash grants, supporting grants, which summed up more than \$ 1 billion US between 1980 and 1992. Between 1982 and 1996 there were 630 subsidies given to the private health care market. (Belek and Soyer, 1995) The total value of these subsidies is estimated to be worth of \$2.2 billion US. 1.3 billion dollars of these subsidies were granted to foreign capital. 479 of these companies were given US 1.8 billion dollars for a brand new complex of health care facilities. 333 private hospitals were given a total US 1.8 billions of dollars in the same timespan. (Soyer, 1994a)

4. One other form of subsidy given to the private health care market was in the form of the increasing expenditures that the public health care sector did in the private health care market. (Belek and Soyer, 1995) The Ministry of Health Hospitals increased their expenditures on medical supplies from the private medical industry from TL 26.6 Billion in 1988 to TL 101.1 Billion in 1991. Meanwhile the SII hospitals' expenditures for medical supplies through the private market skyrocketed from 13.7% in 1980 to 26.2% in 1992. (Yildirim, 1994) The SII hospitals even started cooperating with private hospitals since they could no longer meet the demands of the growing number of their beneficiaries. The total percentage of the expenditures of SII hospitals on private hospital care increased from 6% in 1980 to 22.4% in 1992. By 1994, the SII hospitals referred 10% of their beneficiaries to private hospitals, a cost amounting up to 22% of total SII expenditures. Meanwhile the Bag-Kur safety net spent 52.4% of its funding for medical supplies from the private sector in 1988, a ratio that fell back to 22.2% 1992. The PF expenditures for medical supplies varied between 54-67 %between 1980 and 1992(Yildirim, 1994)

5. Public health care sector providers such as State Hospitals, University Hospitals and SII hospitals contracted out auxiliary services such as sanitizing, security, and laboratory services to the private market. On the other hand the SII Hospitals started the application of sur-time (extended hours of privately-delivered medical services, a practice that was similar to that of the RFS in state hospitals) after 16.00 hours, while State hospitals arranged a dual private bed system for those who could afford the services from the late 1980s on. (Belek and Soyer, 1995)

Expansion of the Private Health care Market: 1980-2000

The private health care sector is composed of: Specialist doctors and health care workers working independently, private polyclinics, private medical laboratories and private hospitals. The pharmaceutical industry and its marketing sector concerned with the supply of medical technologies and medical supplies and private insurance companies are complementing the private tier of the health care sector. I will pinpoint those trends that illustrate the expansion of the private health care market:

1. The private health care market in Turkey is based upon a market that is worth \$ 2_[MG1] million US annually. Yildirim suggests that between 1980 and 1992, Turkish society spent more than \$16US billion in the health care market. Moreover, the per capita private health care expenditure steadily rose from \$27US in 1980 to \$41US in 1996. (Belek and Soyer, 1998)

2. The late-1980s brought about the expansion of private hospitals too. By 1996, the number of private hospitals has risen to 184 from tens during 1970s, while reaching 125 in 1989. Meanwhile, public hospitals experiences an increase from 687 in 1989 to 814 in 1996. It is however important to note that private hospitals only could only offer 10,042 patient beds while the public hospitals offered 129,887 beds. (Belek and Soyer, 1998)

3. The private insurance mechanisms that never existed in the pre-1980s initiated the private funding of the system in 1990 with only ten companies. By 1997, the total number of private health insurance funding companies became 47. The total share of the market that those companies held was worth 964.5 million US Dollars in 1991. The market became worth 1.4 billion US Dollars in 1996. (Belek and Soyer, 1998)

4. The specialized medicine profession became more and more of a private practice in the post-1980s. The medical profession in Turkey has always been a part-time engagement, that is to say, physicians, especially specialists, have always been able to work at both public and private hospitals. In fact, governments have been concerned with this issue since most of the doctors preferred working independent in their private practices. They were not able to track and tax the earnings of the doctors that work in public hospitals and work at the very same time independently as private service providers. In such respect, the governments in the post-1980s have pursued the establishment of an institutionalized private health care market to trace the earnings of the privately working independent doctors. (Ardic, Belek et al, 1992)

5. The pharmaceutical industry has started expanding from the early-1980s on. The medicine industry in the post 1980s constituted more than 15.7% of the whole chemical industry. The degree of monopolization in the medicine industry in the health care market has also been significant. The first five companies take up more than 41% of the whole market. (Belek and Soyer, 1998) Meanwhile the first 20 companies held than more than 82 percentage ownership of the firms involved in the market. In 1971 the first 31 companies within the industry held more than 81% of the market. By 1984 and 1985, these companies in the market controlled 94% of the whole market. (Belek and Soyer, 1998) It was interesting to note that these companies were either foreign capital or Turkish companies that acted as the marketing agents of the foreign pharmaceutical industry.

Locating Political Islam within the Health Care Reform

The triumph of the pro-Islamic Justice and Development Party (JDP-Adalet ve Kalkinma Partisi) in the 2001 elections signified the beginning of a new era. In the aftermath of a devastating financial crisis, the JDP was able to attain an overwhelming number of the seats within the assembly in 2001. Indeed, Turkey's need for a majority government was emphasized by the dominant sections of the capital throughout the 1990s. In fact, before the eyes of such groups, the 1990s were a lost decade which is characterized by fragile, unstable coalitions far away from commitment to the neoliberal project in Turkey.

Nevertheless, the victory of the JDP was not an easy one. In such respect, the rise of Islam-based politics cannot be considered apart from the rise of small and medium-sized manufacturing-based capitalist groups in Anatolia throughout the 1980s and 1990s. As the Anatolian-based capitalists flourished thanks to their integration through the export-led growth neoliberal project and the flow of substantial Saudi foreign capital into the country, political Islam became the spokesperson for these groups in the political arena. (Onis and Keyman, 2003) By virtue of emphasizing the miracle of the NICs, the Welfare Party, from the mid-1980s on, underlined the need for the State to get involved in further industrialization of the country. (Onis, 1996) On the other hand, and rather paradoxically, the same political party utilized the rural and urban discontent with the existing neoliberal project by means of , what they called, "The Just Order" which was based on the expansion of social services for the poor.

The gradual ascension of the Welfare Party in the 1994 local elections was followed by the party's coming into coalition government with the centre right True Path Party. (Kongar, 2002) However, the dominant sections of Turkish capital and the Turkish State establishment had a reluctance to accept the new Anatolian bourgeoisie' representation. (Boratav, 1996) In a setting escalated by secularist debates, the True Path and Welfare Party Coalition came to end in 1998 with a post-modern coup. The latter party was banned by the Supreme Court in a couple of months. (Onis, 2001)

Political Islam, yet, organized once again under the umbrella of the Party of Virtue with a moderate tone in the former themes such as the State's involvement in the economy and social service delivery. The Party of Virtue ended up in being short-lived: By 2000, it eventually split along two lines: the traditionalists and the reformists. As the traditionalist factions of political Islam established the Felicity Party, the reformist groups set up the JDP. (Onis, 2001)

The JDP moderated and realigned its political discourse on the basis of a neoliberal model, with yet a populist and conservative tone. (Onis, 2001) In light of the 2001 Turkish Financial Crisis, was the victory of the JDP an inevitability, given the catastrophic and disastrous ramifications of the crisis on the Turkish political economy setting?

The answer lies in the fact that the JDP government, now that they have been accepted into the neoliberal power bloc dominated by the Istanbul industrial capital with reciprocal concessions on behalf of the military, is handling the completion of the unfinished project of Turkish neoliberalism. Doubtlessly, the JDP government acts on a thin fine line whilst moderating the growing impact of US imperialism, given the influence of the Greater Middle East Project and the invasion of Iraq, and managing pressures from the capitalist and the subordinate classes. In this regard, the JDP has invigorated Turkish health care reform by means of unifying the social security mechanism and the health care system into a single and simple jurisdiction for the service of the social classes. Such a simplification of the welfare regime configuration through a centralization of the system, will contribute to the introduction of growing privatization. Meanwhile, the JDP government opens more doors for capital accumulation to industrial capital, which has been expanding its activities in the private health care system and insurance since the late 1980s.

Concluding Remarks

In an age of Pax Americana, in which unilateralism has been the mode of conduct, the Turkish experience in health care restructuring has been subjected to a prolonged delay until the turn of the century. The final crisis that the country had to deal in 2001 with very well proved the fact that Turkey would no longer be enjoying delaying the process of social service delivery reform with the support that comes from the subordinate classes. Indeed, what has changed is the American hegemony that continuously redefines its interests and its friends and foes and imposes the neoliberal state as the most appropriate unit for the world system.

The so called ‘strategic’ partnership, accorded by the Clinton Administration between Turkey and the United States has faded away –as if it had meant much- in the recent financial crisis. The message is crystal clear: The US would no longer be willing to bail Turkey out whatsoever unless the latter gave unconditional support to the US in the related American operations in the Middle East. Consequently the IMF support packages became conditional upon two factors: The urgent action to be taken about social service delivery reform and other structural reforms within the economy and the military support of Turkey in the Iraqi operation and further coming operations of the US in the region. Yet the rejection of the Turkish assembly to the deployment of American troops in the country has brought about further frustration and complication in US-Turkish relations. Consequently, IMF support for Turkey’s structural transformation programs started to be used as a black-mailing tactic vis a vis the country.

Health care reform is continuously under progress through a recommodification of services and privatization of facilities in Turkey. In the neo-imperial times it is difficult to guess where the Turkish welfare state will go from here, in the auspices of the Empire, but

it is certain that the subordinate classes will have a word in directing the process to alternate routes.

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²In this respect, the lesser influence of the working classes and other excluded sections of the Turkish bourgeoisie is to be considered within the Turkish neoliberal project.

³ For the historical origins of the Turkish development model based on Kemalism, see Mehmet, Ozay. (1983) "Turkey in Crisis: Some Contradictions in the Kemalist Development Strategy" *International Journal of Middle Eastern Studies*, 15, (1983), 47-66

⁴ For more on the historical origins and development of the Turkish welfare state, see Ozbek, Nadir "The Politics of Poor Relief in the Late Ottoman Empire: 1876-1914," *New Perspectives on Turkey*, n.21, Fall 1999, pp.1-33 and by the same author "Osmanli'dan Günümüze Türkiye'de Sosyal Devlet," *Toplum ve Bilim*, n.92 (Bahar 2002): 7-33.

⁵ Most pieces of legislation passed by governments in the past two decades have been annulled by the Supreme Court of Turkey on the grounds that they violated the basic principles of the Constitution: the equity and social welfare notion of the State. My view is that such an occurrence reflects the deep divisions between different levels of the State, the divisions being inextricably linked to the unequal representation within the structure.