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Globalization and Health: An Evaluation on Turkey

1 Introduction

Globalization had first started as the convergence and deepening of the international relations. Later, changing circumstances and political and economic conditions caused globalization to be evolved from a fact to perception by changing its dimension and transforming itself. The actors that had roles in theatrum mundi changed, and the stage became more modern but more ruthless as well in this process. Especially with the liberalization policies after the 1980s, globalization transformed into a new form by achieving a new level.

Despite the nature of social sciences and although globalization is a difficult term to describe and a consensus cannot be achieved for its description, it became an excessively used term in time which is remarkable. Although the term *globalization* generally began to be used commonly in the 1960s, it had been emphasized even before. For instance, there were messages about the globalization of world in Westphalia Peace of 1648. In the same vein, in 1795, Immanuel Kant used the term *cosmopolitanism* (world citizenship) in his *Perpetual Peace* by mentioning a project that embodies all the humanity which aims to envisage to limit the global aggression and to gain a universal prestige to human dignity. There were statements towards globalization in the 19th century as well. Some determinations that Karl Marx and Friedrich Engels made in their work *Communist Manifesto* that was written by them in 1848 and has been accepted as the creed of communism emphasized the significance of globalization as well. However, it can be claimed that these examples are far from the notion of globalization nowadays.

Globalization is a fact and even perception that involves several concepts and enormously has been referred in the usages other than its real meaning. Because historical accumulation and perception is indispensable to even mention globalization; therefore, although an absolute political or economic term has not been mentioned; it is possible to define globalization as a process that involves and embraces all of the political, economic and historical connections, relations of production and capital movements. In other words, it will be appropriate to consider the globalization as an alteration movement rather than a transformation.

The aforementioned alteration has given birth to some consequences in the health sector as well as every field. The different countries that have been implementing various economic policies have prepared similar health programs with each other with globalization, and health has become a problem in global scale.

2 Reform in Public Sector

Capitalism, that is called as "Neoliberalism" these days, was radically transformed in the center and nearby countries during the transition process that took place in the 1970s and 1980s. Neoliberalism is the ideology of the benefits of both market and private sector unlike the state intervention into the economy. It is a new social order where the power and incomes of upper classes of ruling class were rebuilt entirely after a period of regression (Horton, 2007: 1). In this regard, the targets of neoliberal policies can be summarized as reviving free market and perfect title and in the cases where there are no markets and property rights have been limited, implementing this mechanism or the counterparts of it into every field (to soil, to water, to every other natural resources, labor force, delivery of public services and international economic relations) and if it is necessary, even implementing these policies with state intervention (Boratav, 2013: 34).

In microeconomic level, neoclassic theory acknowledges the activity of market rather than state. The state intervention and ownership have disrupted the resource allocation and produced wastage. On the other hand, the enormous state activity has originated injustice on apportionment by distributing rents to the cream of society. It is advocated that the market should take care of economic development issues such as industrial growth, international competition and employment. According to this thought, the state should be pushed aside and the construction of required legal and economic infrastructure for national defense and functioning market should be the issues that state should be interested (Saad-Filho, 2008: 193). In this regard, it can clearly be seen that neoliberal policies are dominant today. These are the deregulation of financial markets, the debilitation of the protections on labor unions and labor market with social protection institutions, the minimization of state activities, the reduction of the top tax brackets, the development of international goods and capital markets and the renouncement of full employment under the disguise of natural rate. "Washington Consensus" dominated the international economic policy, and it advocated the liberalization, free market, export-oriented growth, financial capital mobility, deregulation of labor market and macroeconomic austerity policies. In the center of "Washington Consensus", ten primary proposals were suggested for the reform in policies, and the five of them were closely related with health policies. These are as follows:

- Financial discipline,
- Redirecting the priorities of public expenditures into the fields, that have both high economic return and the potential to provide justice in income distribution, such as the primary care health service, primary education and infrastructure,
- The liberalization of cash flows and foreign direct investments,
- Privatization,
- Liberalization (the abolition of barriers for the entry and exit to the markets) (Williamson, 2000: 252–253).

Since the destruction of Berlin Wall in 1989 and the dissolution of the USSR, capitalism has comprised of hegemon economic framework almost in every countries. All of the reforms that have been applied since the end of 1980s have been shaped in a large spectrum without differentiating the countries whether they are poor or rich (Lister, 2005). As a matter of fact, a wide section of literature assumed that the capitalist market has presented an appropriate model for developing health care and health reform.

In essence, the reform works that represent a new phase in the policies of health care have been originated from *global faith to the market mechanisms* (George ve Wilding, 2002: 64). "Structural Adjustment Programs" were put into practice in the 1980s with the expansion of neoliberalism, and they were implemented as the condition to take credit from International Finance Corporation. The countries that have encountered with the balance of payment problems due to debts or foreign currency crisis may borrow from these institutions such as IMF and World Bank under one condition, accepting stability and structural adjustment programs that have been recommended by IMF and World Bank. Since the number of poor countries that was forced to accept at least one of these kind of programs became approximately a hundred during the past twenty years, it can be argued that the neoliberal policies were imposed across the globe by increasing the programs (Saad-Filho, 2008: 191–194). In conclusion, it may be held forth that the reform discourse in the health sector has appeared as a result of these impositions (Lister, 2005).

3 Reform in Health Care

The reform works in the health sector have gained wide currency in several countries, and a wide coverage has been given to them in the literature of health economics. The problems, that the countries have encountered, such as aging, new methods of treatment and advanced technology have paved the way for the reform works by creating pressure towards the increase of health expenditures (Saltman and Figueras, 1998: 3). Some of the reasons for health reform are the inefficient use of the sources, lack of access to the health care that are required for individuals and health care that cannot meet the requirements of individuals (Cassels, 1995: 330). On the other hand, it is noteworthy that governments with different political views apply similar reform packages in the poorest and developing countries, as in high- and middle-income countries (Lister, 2005). In this regard, the reform policies in the health industry that took place in Western, developed economies since the second half of the 1980s are among the most significant initiatives of the countries (Flood, 2003: 1). Eastern European countries expand their social insurance programs, South American countries expand the scope of their health insurance to include the poor people who live in rural and urban areas, the financial decentralization has been using for generating additional resources to the hospital in Africa and for increasing the efficiency, and several countries have been using drawback systems and the organization of the delivery of health care. Furthermore,

globalization supports the demand of the health care. Along with the elements, that enlighten the individuals more about the health care field, such as internet and media, the desire for continuous consumption affects health care both quantitatively and qualitatively. Individualistic expectations require the best care along with the latest technology and these conditions suppress the governments (Roberts et al., 2009: 3–17).

In this regard, there are two main reform trends within the frame of neoliberal policies. First is the reforms towards reducing the costs and it has been applying since the 1970s. Second is the policies that aim to reconstitute health care system with the aid of market style mechanisms and it has been applying from the 1990s till date (Lister, 2005). The structural and administrative reforms in the health care can be labelled as the initiatives that seek to find a cure against the constant failures of profit-oriented capitalist system about introducing health care which is affordable and fit for the global market. Within this context, the "new public administration" policies in the health care can be considered as *marketization reforms* (Preker and Harding; 2003: 2).

4 The Reform Implementations on Health Sector in Turkey

The reform works towards the health care have been initiated with the declaration of Republic in Turkey. Along with the delivery of health care with good quality, the fair distribution of health care and the improvements on health indicators were aimed with the aforementioned reform works. Until the beginning of the 2000s, the desired result cannot be achieved with the intended reform works and the realized economic crises affected this process negatively as well. Health indicators fell behind the developed countries, the problem of financing on health care and the budget deficits of social security institutions grew, the irregularity of regional distribution of the delivery of health care could not be fixed, and the hydra-headed structure in health sector could not be altered.

The hint of policy changes towards health was given in the "Immediate Action Plan" with the government reshuffle of November 3, 2002 and an extensive notion of reform brought to light. The articles of indicated policy in the mentioned plan can be organized as follows: *"Within the scope of targets such as the creation of an effective healthcare system with good quality, the execution of primary healthcare of everyone by cooperating with private sector, equalizing the distribution of healthcare at the national level in Turkey; In a year; i) The works towards abolishing the distinction of public hospital, insurance hospital and institutional hospital will be initiated, ii) The works for providing the administrative and financial autonomy of hospitals will be started, iii) The System of General Health Insurance will be established, iv) The execution of family practice will be constituted and a durable conveyor chain will be formed, v) The preventive medicine will be popularized, vi) Private sector will be encouraged to make investments to the healthcare field. Within the*

Tab. 1: Number of Hospitals by Years and Sectors

	2002	2017
Ministry of Health	774	879
University	50	68
Private	271	571
Other	61	-
Total	1.156	1.518

Source: Health Statistics Yearbook 2017, Ministry of Health

frame of the principle that the people live under the securest economic and social conditions without discrimination, again in a year; i) The norm and standard unity in the social security institutions will be provided, a unified social security network will be installed, ii) In order to enable the creation of an integrated social service and assistance network, the disorganized social service activities will be gathered under the same roof, iii) The resources of Fund for the Encouragement of Social Cooperation and Solidarity will be increased, the procedures and principles of expenditures will be redetermined and governing structure will be strengthened." In this sense, the political suggestions in the "Immediate Action Plan" have laid the foundations for an extensive reform thought in the health and social security systems (DPT, 2002: 11).

When the objectives in the above have been evaluated, the reform works of Turkey have also included the finance of health in the same time for the most part. Especially gathering several social security institutions under the same roof is quite significant in terms of justice for financing and usage. On the other hand, it was desired to actualize a strong health system with the executions such as general health insurance and family practice. This objective was supported with the unification of all providers of health care. In the meantime, the encouragement of private sector to make investments into the health sector can be considered as a reflection of "liberalization" thought that has been accelerated with globalization and has been mentioned in Washington Consensus before.

With the Health Transformation Program, it was aimed that private sector will make investments into the health sector more than before. Thus, the deficiency of providers of health care will be overcome, and the service uses of individuals will be supported. Tab. 1 demonstrates the number of hospitals with regard to the sectors for the years 2002–2017 in Turkey.

As it is seen in Tab. 1, there are 1156 hospitals in Turkey by year 2002. A total 774 of them is public, 50 of them is university, 271 of them is private and 61 of them is other hospitals. In this regard, the delivery of health care was substantially actualized through public sector. The private sector was encouraged with the reform program of 2003, and the number of private hospitals rapidly increased. By the year 2017, the number of private hospitals reached 571. Therefore, the existence of

Tab. 2: Total Number of Visits to a Physician by Years

2002	2008	2010	2012	2016	2017
208.966.049	527.566.394	539.085.967	621.786.297	685.709.179	718.924.809

Source: Health Statistics Yearbook 2017, Ministry of Health

private sector in the health sector can be seen intensively, and it is stated that the health sector gained a place in the market.

On the other hand, the significant obstructions in the access to the providers of health care were removed with HTP and the access of individuals to the providers was eased at the same time. It is seen that the service providers of public, private and university hospitals were more intensely used specifically as a result of the unification of public hospitals and the abolition of conveyor chain. Tab. 2 demonstrates total number of visits to the providers of health care by years.

The total number of application to the providers of health care was approximately 209 million in 2002 in Turkey. The chance to access the providers of health care was eased in 2003 with a new application, and the share of population within the scope of social security increased by years. As a result of these factors, the number of application to the providers of health care showed an increase as well. Within this context, while there were 527 million applications in 2008, this number increased to 621.7 million in 2012. The increase of this issue can be evaluated as extraordinary; it can also be held forth that this condition is actually originated from the improvement in access to the providers of health care for the population with green card. As a matter of fact, the scope of social security was expanded with the realization of General Health Insurance dated 1 January 2012, and as a result, the number of applications to the providers of health care increased. Moreover, the number of applications reached approximately 719 million in 2017. When it is considered that the rate of application to the physician per capita is 7.2 in average in OECD countries, Turkey is located in quite high levels with the rate of 8.6 (OECD, 2018). This condition, however, gave rise to a thought that redundant applications have been made to the providers of health care and as a consequence, the expenditures have unnecessarily been increased.

The increases in the number of applications to the providers of health care by the individuals within the demand for health care and the abolition of obstructions in front of these applications are undoubtedly positive in terms of the welfare of society. However, the rapid increase in demand here is affecting the health expenditures, and as a result this condition affects the sustainability and finance of health negatively. Hence, the encumbrance on the state budget with the huge deficits that social security system has through the health expenditures can be

characterized as an enormous threat on the health care for the following years. Therefore, the co-payment has been put into practice with the intent of financing the expenditures in the health care system. Decreasing the number of redundant applications and the contribution of health care of users into the finance of health care have been targeted. The definition of current co-payments is as follows: *"In order to benefit from the healthcare, amount to be paid for the people with general health insurance or dependents"* (SUT, 2019). Besides, their amounts are mentioned below:

- 6 TL in the providers of secondary health care,[11]
- 7 TL in the training and research hospitals of ministry of health which have been used with universities collectively,
- 8 TL in the tertiary health care providers which are affiliated to university hospitals,
- 15 TL in the private providers of health care.

On the other hand, the co-payments have also been taken for the drugs that have been provided as a result of ambulatory treatment: i) For the medicines paid by SSI, 10 % of co-payments from the income and monthly recipients of SSI and their dependents, and 20 % of the other persons are charged. ii) Besides, for each and every prescription, 3 TL for drugs supplied in up to 3 boxes (including three boxes) and 1 TL for every box that has been provided in addition to 3 boxes has been taken as a co-payment. Nevertheless, the practice of co-payment is affecting the welfare of household negatively, and households are becoming poor due to the health expenditures (Yereli et al, 2014).

Another reform application that neoliberal health policies have caused specific to Turkey is "City Hospitals" within the scope of public-private partnership. It is held forth that a market centric and profit-oriented financing system has been implemented with the aforementioned application. (Pala et al, 2018: 44). In this regard, ministry of health has 31 city hospital projects with 44.409 beds in total. One of these projects is Ankara-Bilkent Hospital, and it is indicated that this hospital will be the world's biggest hospital with 3.704 beds (Ministry of Health, 2018).

PPP has been defined basically as *"contractual partnerships between public and private sector agencies, specially targeted towards financing, designing, implementing, and operating infrastructure facilities services that were traditionally provided by the public sector"* (Chakravarty et al., 2015: 129), and it has been aimed at the risk and reward sharing between public and private sectors with PPP. However, it has been considered that both the encumbrance on the budget will be increased and additional payments can be demanded from the patients as a result of that application (SASAM, 2018: 90).

11 1 US $ = 6 TL, 22.05.2019

5 Conclusion

A transformation has occurred in both supply and consumption of semi-public goods and services, such as health and education with the influence of globalization. Both structural adjustment programs and internal dynamics of countries hastened this change, and it evolved into a general structure. Reform and alteration in health care field accelerated especially with the application of neo-liberal policies after the 1980s. At the helm of the most common problems of the countries, older population, chronic and contagious diseases and therefore, the unemployed population who are out of economic production mechanism due to these aforementioned medical problems take the lead. Thus, the mentality and pursuit of reform that had begun in health sector with the 1980s continue today as well.

Although the health reforms had started in Turkey with the first years of country, these activities advanced enormously in 2003. Health reform gained a modern structure with the Health Transformation Program. Improvements have been observed especially in the number of hospitals and delivery of health care and access to the providers of services eased.

While the total number of application to the providers of health care was approximately 209 million in 2002 in Turkey, this number reached 719 million in 2017. Therefore, the co-payment has been put into practice with the intent of financing the expenditures in the health care system. In fact, the costs that have been used by the householders for the usage of health care increased due to the measures such as the co-payment and additional payment and by this way, they have been impoverished. In conclusion, it can be held forth that catastrophic health expenditures will increase and the welfare of household will be affected negatively with them as well.

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