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Assessing the Health-economic Crisis: The Case of Turkey

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ABSTRACT

With the transition to neoliberalism, health has tended to be less regarded as a social obligation and become instead an individual responsibility. Hence, the issue of healthcare has gained a "health-economic" character by increasingly integrating health systems into the existing economic situation and market dynamics. Introduced in the 2000s, the Health Transformation Program (HTP) represents such an approach in Turkey. This article reports on field research carried out in Istanbul into the consequences of the HTP through a survey focusing on healthcare facility preferences and perceptions of the most critical problems of the healthcare system. The survey was carried out in 2019 with 5002 participants aged 25-65 using the face-to-face technique and frequency and Pearson chi-square analyses to summarise the findings. The privatisation trend is shown by public-to-private comparisons of health expenditures, hospital beds and admissions to hospitals, while the shift toward private hospitals is mitigated by participant preferences for the public healthcare schema, which remains the central pillar of the system. This preference is mainly based on the economical services provided in public hospitals, while the shift to the private system is argued to be largely impelled by increased patient density in the public system resulting from the neoliberal logic of the HTP. In conclusion, the need for a new reform program that will invest in the public nature of the Turkish health system is identified and addressed.

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Introduction

As a way out of the economic crises of the 1970s, the advancement of the neoliberal structural adjustment policies to "free" the market mechanisms from the influence of the political sphere has been implemented, paradoxically, through extensive use of state power. The underlying rationale of neoliberalism was that eudaemonia could "best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets, and free trade" (Harvey, 2005, p. 2). The transposition of this relationality to the realm of healthcare can be read as having produced a "health-economic crisis" that involves "the declining capabilities of public healthcare" and a fostering of the interest of the private sector in service provision (Williams and Maruthappu, 2013, p. 7). In other words, this crisis developed with the transition to neoliberalism.

Unsurprisingly, the "healthcare reform" initiatives of the World Bank (WB) and International Monetary Fund (IMF) from the 1980s have centred around the economic value of healthcare services that are ineffectively and inefficiently provided by the public sector and have aimed to create internal markets or contracts between the state and private providers that would boost quality care (De Vogli, 2011; Mills, 1995, p. 30; Navarro, 2000, p. 1601; Sen and Koivusalo, 1998, pp. 199–201). However, rather than producing positive results in economic terms, already by the 1990s, there was already substantial

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evidence from the various "healthcare reform" experiences that this development was having a negative impact all around the globe, especially on vulnerable populations (Bennett, 1991; Bijlmakers, Bassett and Sanders, 1995; Bogg, Dong, Wang, Cai and Vinod, 1996; Creese, 1991; Green, 1995; Kanji and Jazdowska, 1993; Kentikelenis, 2017; Sauerborn, Nougtara and Latimer, 1994; Sen and Koivusalo, 1998; Watkins, 1995).

With its stabilisation program enacted on 24 January 1980, Turkey, characterised as an "emerging market" or a "middle-income country," was one of the first countries to initiate such a neoliberal structural adjustment, (Aktan and Bulut, 2008; Alper and Onis, 2003; Senses, 2016; The World Bank, 2019; Yalman, 2010). Despite some preparatory works in the 1980s and 1990s, however, the reform program in Turkey came into effect more fully relatively late. It was not until 2003 that the Health Transformation Program (HTP), initiated by the new government of the Justice and Development Party (JDP),[1] emerged as part and parcel of the deepening of neoliberalism in Turkey.

The neoliberal drive in Turkey was associated with the re-regulation programs of the 2000s, broadly in line with the post-Washington Consensus and the regulatory wave of neoliberalism. With the HTP, the beneficiaries of the state Social Insurance Institution (SSI) started to pay contributions toward prescription costs at state-owned hospitals. In 2008, General Health Insurance (GHI) was implemented, which covered all citizens in return for premiums to be paid by those whose (monthly) income was over one-third of the gross minimum. Additionally, the SSI introduced the public procurement of healthcare services from private institutions, increasing the share of private entrepreneurship in healthcare. Public hospitals were also encouraged to be more competitive by changing their management structures and understandings. Thus, healthcare was both handled within the framework of social obligation as a human right and also rapidly privatised and commercialised through the neoliberal transformation and placed into the field of individual responsibility (Aykan and Güvenç-Salgirli, 2015, p. 74; McGregor, 2001, p. 84; Senses, 2016, p. 15; Terzioglu, 2016, p. 150). As a result of this increasing integration into the existing economic situation and market dynamics, healthcare in Turkey, too, has gained a "health-economic" character. This character has become associated with the HTP, influencing the perceptions of the welfare state and public services (Konuralp and Dayıoğlu, 2022).

Following what was then a 16-year implementation period of the HTP, in 2019, we investigated the effects of this on healthcare facility preference and the most critical healthcare system problems. This article elaborates on our primary findings in that field research, conducted to draw attention to people's perceptions of the HTP, mainly regarding their experience of the public provision of healthcare services in Turkey. Notably, this study presents inferences about the capacity of the Turkish healthcare system to cope with the health-economic crisis just before the coronavirus disease 2019 (COVID-19) pandemic emerged at the end of 2019 and the concomitant economic recession.

This research aims to contribute to the literature by providing empirical evidence of health service users' experiences and perceptions affording insights into their views on the theoretical premises of the neoliberal transformation in the Turkish healthcare system. Hence, a critical political economy perspective in the analysis of the health transformation is supported by research into the views of the public. It is the lack of such an approach to interpreting how the deepening of neoliberalism in Turkey affects healthcare utilisers and why this deepening leads to a health-economic crisis that makes this study an original contribution.

Materials and Methods

The field research on the reasons for healthcare facility preference and perceptions of the most critical problems of the healthcare system in Turkey was conducted by applying a structured questionnaire administered to volunteer participants. The questionnaire was created by reviewing the literature

[1] Turkish: *Adalet ve Kalkına Partisi* (AKP).

and taking expert opinions. The participants were asked about their age, sex, marital status, education level, occupation, household income interval, and social security status to draw a picture of the socio-demographic characteristics of the sample. Then, they responded to questions concerning their preferred type of healthcare facility; the reasons for their preferences; whether their choice would change in the case of a specific type of health problem (dental, ophthalmic, surgical or oncological); the frequency of admission to hospital; their preferred ways of scheduling an appointment at a public healthcare institution; their views on the most important problems of the healthcare system; and the relationship between healthcare policies and electoral behaviour.

The study received ethical approval from the Human Subjects Ethics Committee of the Istanbul Yeni Yuzyil University, Istanbul, Turkey. Prior to the field research, preliminary versions of the questionnaire were applied to 200 and then to 100 people, enabling adjustments to some statements and questions. The final survey was conducted in Istanbul between January and March 2019, using the face-to-face technique for 5002 people aged 25-65 with a primary or higher level of education.2 The collected primary data was analysed by the SPSS Statistics 24. Frequency and Pearson Chi-Square analyses were made, enabling the utilisation of the frequency tables and crosstabs produced to help summarise the findings.

Results

Table 1 shows the socio-demographic characteristics of the sample. Almost half (49%) of the 5002 people surveyed were female, 25.4% were in the 25-30 age group, 41.8% had (only) primary education, 69% had social insurance through the 4/a branch of the SSI (for workers), 3.7% had private health insurance in addition to their state social protection (SSI), 51.1% were employed, and 68.4% had a household income between 2000 and 5000 Turkish lira (TRY).

Table 2 shows the research sample's healthcare facility preferences and frequencies of going to a hospital. Public hospitals were preferred by 58% of the participants, with 19.2% attending a hospital once every six months.

Analysis of the results showed that when there was a health problem, the health institution preference did not vary by gender, marital status or the number of people living in the household. As age increased, the preference for a public hospital increased from 54.9 to 63.3%, and the choice of a private hospital decreased from 15.7 to 6.1% (p=0.0005). As the level of education increased, the preference for a standard or a training and research public hospital decreased – from 63.5 to 47.2% and from 26.1 to 16.9%, respectively – whereas private hospital preference increased – from 5.1 to 25.8% (p=0.0005). In terms of profession, employers preferred public hospitals least (42.3%) and private hospitals most (23.0%), while those who chose private hospitals least were retirees (4.7%), housewives (6.6%), and the unemployed (8.2%). Higher per capita income correlated with reduced preference for a public hospital (falling from a high of 65.0% to a low of 48.3%) and increased the preference for a private hospital (from 4.7 to 20.6%) (p=0.0005).

As shown in Table 3, a public hospital was generally preferred when there was a health problem because it is economical (71.8%). The main reasons for choosing a training and research hospital were that it is economical (42.6%), and its service quality is higher (38.2%). While the university hospitals were mainly preferred due to quality service (47.3%) and trust in doctors (45.0%), the reasons why private hospitals were preferred were quality service (48.9%), lower patient density (38.5%) and shorter waiting time (35.3%). The reasons for the different healthcare facility preferences did not differ according to gender or marital status.

[2] In the literature, a sample of 384 is considered sufficient if the research population is over 100 thousand (Sekeran, 1992, p. 253). Therefore, the fact that this research is based on a sample of more than five thousand is more than sufficient in terms of the validity and reliability of the study.

Table 1. Socio-demographic Characteristics

n=5002		Number	%
Sex	Female	2.458	49.1
	Male	2.544	50.9
Age	25-30	1.273	25.4
	31-40	1.357	27.1
	41-50	1.208	24.2
	51-65	1.164	23.3
Education status	Primary school	2.093	41.8
	High school and equivalent	1.475	29.5
	Associate degree	378	7.6
	Undergraduate degree	877	17.5
	Graduate degree	179	3.6
Marital status	Married	3.538	70.7
	Single	1.464	29.3
Work status	Working	2.557	51.1
	Not working	2.445	48.9
Profession	Private sector (employee)	1.470	29.4
	Public employee	572	11.4
	Self-employed	301	6.0
	Employer	214	4.3
	Retired	664	13.3
	Housewife	1.134	22.7
	Student	221	4.4
	Unemployed	426	8.5
Insurance	4/a (worker)	3.450	69.0
	4/b (self-employed)	578	11.6
	4/c (public employee)	415	8.3
	General health insurance	282	5.7
	Private health insurance	185	3.7
	NIL insurance	271	5.4
Number of people working in the household	None	544	10.9
	1	2.375	47.5
	2	1.613	32.3
	>=3	470	9.3
Number of people living in the household	1	235	4.7
	2--3	2.079	41.6
	4--5	2.263	45.2
	>5	425	8.5
Total monthly household Income (TRY)	2000 and less	391	7.8
	2001-3000	1.282	25.6
	3001-4000	1.150	23.0
	4001-5000	988	19.8
	More than 5000	1.132	22.6
	NIL Income	59	1.2
Monthly income per capita (TRY)	≤500	675	13.5
	501-1000	1.645	32.9
	1001-1500	1694	33.9
	>1500	929	18.6
	Nil (no income)	59	1.2

Table 2. Preferred Type of Healthcare Facility and Frequency of Admission to Hospital

n=5002		Number	%
Preferred healthcare provider in general when there is a health problem	Standard public hospital	2.900	58.0
	Training and research (public) hospital	1.221	24.4
	Private hospital	559	11.2
	Family physician	179	3.6
	Foundation university hospital	66	1.3
	Public university hospital	65	1.3
	Private practice	12	0.2
Frequency of admission to hospital	Several times a month	639	12.8
	Once a month	626	12.5
	Once two months	642	12.8
	Once three months	917	18.3
	Once six months	959	19.2
	Once a year	783	15.7
	Less than once a year	436	8.7

The (low) cost of a healthcare institution became a vital factor as age increased and the level of education and per capita income decreased. In this respect, for example, as the income level dropped, the frequency of public hospital preference for economic reasons increased (from 65.9 to 77.1%). Also, the hospital being within easy reach and trust in doctors were considered important twice as often in upper-income than in lower-income groups. Among the occupational groups, the frequency of public hospital preference for economic reasons was highest among students (79.5%), while service quality was considered the least by the unemployed (11.1%).

Table 3. Healthcare Facility Preference Reasons (%)

Reason	Preferred healthcare facility				
	Public hospital	Training and research hospital	University hospital	Private hospital	Family physician
It is economical	**71.8**	**42.6**	14.5	5.9	29.6
It provides quality service	18.5	**38.2**	**47.3**	**48.9**	6.7
The doctors are good	18.2	31.5	36.6	25.1	19.0
It is close to home	26.1	21.5	19.8	18.8	**70.4**
It is easy to reach	18.0	13.2	16.0	9.7	**47.5**
The patient density is low	2.2	3.1	9.2	**38.5**	15.6
I don't wait too long	2.5	2.5	6.9	**35.3**	16.2
Inspection time is sufficient	2.1	2.5	6.9	7.2	5.6
I trust the doctors	16.1	27.8	**45.0**	20.1	12.8
I can get friendly service	2.3	2.7	10.7	13.1	4.5

p=0.001 (Pearson chi-square analysis)

Most (60%) participants reported that they preferred scheduling appointments by calling 182 (the phone number for the Centralised Doctor Appointment System, CDAS), while 32% used online scheduling, and 8% made appointments at the hospital. As age increased, the preference for making an appointment for the public hospital by calling 182 and by going to the hospital each increased, respectively, from 47 to 71.6% and 6.6 to 12.2% (p=0.001). Making appointments over the internet by registering on the CDAS increased with education level, from 16.9 to 48% (p=0.001). While housewives (71.4%) and retirees (70.2%) preferred to make appointments over the phone, the largest internet preferences were shown by public employees (45.5%) and students (55.2%).

Some 45.8% of the participants stated that the choice of hospital type varies according to the health problem they have. In other words, the participants reported that the type of hospital they preferred differed for ophthalmic and dental health problems, in cases requiring surgery and in the treatment of cancer. As the level of education increased, the choice of hospital was increasingly affected by the type of health problem (rising from 34.7 to 64.7%). A similar positive correlation was observed in terms of income level. Overall, while a public hospital was preferred for surgery, a training and research hospital was preferred for cancer treatment and a private hospital was preferred for dental or ophthalmic problems. A private practice operated by one or several dentists was also frequently preferred for dental treatment, whereas hospitals providing a public health service were less preferred (Table 4).

Table 4. Hospital Type Preference According to Health Problem

		n	**%**
Does your choice of hospital type change according to the health problem?	Yes	2.290	45.8
	No	2.712	54.2

Type of health problem		**Dental** (%)	**Ophthalmic** (%)	**Surgical** (%)	**Oncological** (%)
Type of hospital	Public hospital	19.3	**38.6**	**40.2**	**31.1**
	University hospital	3.8	4.8	8	11.9
	Training and research hospital	5	10	27.3	**43.8**
	Private hospital	**51.6**	**46.4**	27.1	15.9
	Private practice	**23**	2.5	0.3	0.3

The four most critical problems in the healthcare system were stated as (in descending order) patient density, difficulty of making an appointment, high co-payments and failure of the SSI to cover all medicines and treatments. Gender, age and marital status did not affect this assessment. Higher education level raised the assessment of patient density as the most important problem, followed by non-coverage of all medicines and treatments by the SSI and commercialisation in the healthcare system. As per capita income rose, the view that commercialisation in health is one of the most critical issues increased from 29.8% to 39.8%. Those who preferred private hospitals tended to do so because of the difficulty in scheduling an appointment in the public hospital, high patient density, and poor quality of service (Table 5).

Table 5. Most Important Problems in the Healthcare System

n=5002	**n**	**%**
High patient density	2.554	51.6
Difficulty in making an appointment	1.955	39.5
High contribution fees	1.773	35.8
Non-coverage of all medicines and treatments by the SSI	1.672	33.8
Commercialisation in the health sector	1.668	33.7
Insufficiency of the health personnel	1.661	33.6
Failure to continue treatment with the same doctor	1.566	31.6
Too short inspection time	1.498	30.3
Equipment/device insufficiency	1.354	27.4
Unclean hospitals	1.347	27.2
Insufficient number of public hospitals	1.239	25.0
Low quality of service in hospitals	1.203	24.3

The most critical problems of the health system were given as patient density, out-of-pocket expenditures, and service quality. In this respect, when we group participant priorities in service utilisation as timely, economical and good quality care, we infer that the priority was to receive timely services (42%), depending on patient density and difficulty in making an appointment. Timely care was followed by economical care (32%) and quality care (25%).

Just over two-thirds (68%) of the respondents stated that healthcare policies influence their voting preferences. The relationship between the applied healthcare policy and electoral behaviour did not vary significantly according to socio-demographic characteristics (gender, age group, marital status, education level, profession and income). However, those who maintained that health policies affect their voting preferences were much more inclined to report problems with the healthcare system. For example, the rates for problems were 6.6% higher on average among those who thought that voting preference was affected by the healthcare policy.

Discussion and Conclusions

Together with stabilisation, liberalisation, and deregulation, privatisation is an indispensable tool that neoliberal approaches utilise to open up economies (Summers and Pritchett, 1993, p. 383). On the one hand, in the context of the neoliberal transformation of the welfare state model, privatisation means not only selling public entities to private companies but also sharing the role of the state with the private sector in the delivery of public services. Therefore, unsurprisingly, the explicit neoliberal orientation of the HTP in Turkey was infused with the thrust of privatisation. On the other hand, neoliberal structural adjustment policies aiming to "free" market mechanisms from the political domain and cope with (supposed/perceived) market failures well as crises like climate change paradoxically require state power (Gürçam, 2022; Gürçam and Konuralp, 2021; Gürçam, Konuralp and Ekici, 2021; Konuralp, 2020; Konuralp and Bicer, 2021). This paradox expresses the indispensability of the public nature of the relations of production in today's world.

The trend of privatisation in the Turkish health system is evident when we compare its population, per capita health expenditure and the numbers of hospital beds and admissions to hospitals between 2002 and 2018. Population growth during this period was 23% (TurkStat, 2020). In real terms, public and private health expenditure per capita increased by almost 55% (from 1294 TRY to 2030 TRY at the 2018 price level), which still left Turkey among the lowest per capita spenders on health in the OECD, at around a quarter of the average (OECD, 2019; TurkStat, 2022).

When we examine health expenditure over the last two decades of JDP rule in Turkey, we see that hospital revenues increased disproportionately and households spent more on health, while the SSI occupied the lion's share of health expenditure. The percentage of hospital spending within the total health expenditure increased from 32 to 50% between 2002 and 2020. The share of the SSI rose from 41 to 51%, while the share of the central government remained unchanged (28%). Although the percentage of household health expenditure has decreased (from 20 to 16%), it would be misleading to interpret this to mean that the burden of health expenditure on households has been diminishing (Table 6). As Konuralp and Bicer (2021, pp. 664-665) put it,

> [T]he rate of increase in public health expenditures is much higher than the rate of increase in household health expenditures. This stems from the transfer of public funds to the private sector by public procurement of healthcare services from the private sector. Thus, the decrease in the share of household health expenditures within the total health expenditures does not indicate any decrease in out-of-pocket

expenditures. On the contrary, the cost of healthcare services both for the public and for households has risen with the HTP.

Considering the fact that real out-of-pocket health expenditures per capita at the 2019 price level in TRY rose from 296 to 407 between 2002 and 2019 (MoH, 2021, p. 248) and per capita income has been decreasing in Turkey since 2013, the health-economic crisis impairs households at an increasing rate.

Table 6. Inflation-adjusted Health Expenditures in Turkey between 2002 and 2020[(1)]

Year	Overall total	Public total	Central govt.	Local govt.	SSI	Private total	House-hold	Other [(2)]
2002	59 411	41 993	16 718	1 126	24 149	17 418	11 788	5 630
2003	63 226	45 474	16 452	1 256	27 766	17 753	11 672	6 081
2004	71 992	51 293	18 366	1 199	31 728	20 699	13 850	6 849
2005	78 401	53 186	21 108	1 035	31 043	25 215	17 848	7 367
2006	89 208	60 964	23 818	1 383	35 763	28 244	19 602	8 642
2007	94 794	64 302	26 007	1 615	36 680	30 492	20 680	9 812
2008	97 369	71 095	26 894	1 458	42 742	26 273	16 924	9 351
2009	91 776	74 310	28 440	1 057	44 813	17 466	12 903	4 563
2010	90 040	70 776	25 123	842	44 811	19 264	14 690	4 575
2011	94 112	74 869	26 181	764	47 925	19 242	14 526	4 716
2012	93 437	74 036	20 772	834	52 430	19 400	14 799	4 602
2013	98 933	77 641	21 600	950	55 092	21 292	16 595	4 697
2014	101 991	78 990	22 908	801	55 281	23 001	18 105	4 896
2015	104 568	82 121	25 286	927	55 908	22 446	17 315	5 131
2016	111 091	87 209	26 652	1 037	59 520	23 881	18 147	5 735
2017	117 402	91 606	29 480	1 087	61 039	25 796	20 037	5 759
2018	118 617	91 903	29 046	1 033	61 824	26 714	20 571	6 144
2019	125 253	97 706	32 082	855	64 769	27 546	20 951	6 595
2020	138 697	109 913	38 250	906	70 757	28 784	22 256	6 528

(1) Million TRY, 2015=100

(2) Other: health expenditures of private social insurance schemes (bank funds), non-profit organisations serving households, state economic enterprises, foundation-owned universities, institutions covered by privatisation and all other enterprises.

Source: Author, based on nominal data from the Turkish Statistical Institute (TurkStat, 2022).

Further to the absolute rise in overall healthcare expenditure, the effects of the privatisation of healthcare in Turkey are also evident in the number of hospital beds and admissions to hospitals. According to the Republic of Turkey Ministry of Health (MoH), the total number of hospital beds increased by 41% from 2002 to 2018, during which time the share of public hospital beds decreased from 76 to 60%; the number of private hospital beds increased by 305%, while their share increased from 8 to 22% (MoH, 2019) (Table 7).

These numbers give an idea of the supply side of the overall picture (i.e., of an increased provisioning of hospital beds, massively from the private sector). On the demand side, the privatisation drive becomes even more evident. The total number of admissions to hospitals increased by 301% during the 2002-18 period, primarily due to a 1211% increase in those to private hospitals, reflecting an increase in their share from 5 to 15%.

Table 7. Number of Beds in Hospitals and Admissions to Hospitals

Number of Beds in Hospitals							
		MoH		University		Private	Total
2002	125743	76%	26341	16%	12387	8%	164471
2018	139651	60%	42066	18%	50196	22%	231913
Increase	11%		60%		305%		41%
Number of Admissions to Hospitals							
		MoH		University		Private	Total
2002	109793128	88%	8823361	7%	5697170	5%	124313659
2018	380623055	76%	42665139	9%	74675065	15%	497963259
Increase	247%		384%		1211%		301%

Source: Data collated from MoH (2019).

With the increases in hospital bed and admission numbers, it can be argued that the HTP has increased the accessibility of healthcare services; however, the other side of the coin is that without a considerable increase in the supply of *public* healthcare services, this would also mean overutilisation of those healthcare services – unless people essentially move from the public to private system. The increase in admissions to public hospitals maximised resource usage of some (e.g., provincial) facilities, which had previously been massively underused (for various reasons, such as understaffing), but in the larger cities, where this was not the case and where most of the population now lives, it tended to increase already high patient density and thus operated as a motivator for people to go to private hospitals. Such overuse is necessary to create the demand for a new (and more expensive) marketplace for private corporations and, thereby, the transfer of public funds to the private sector (Weisbrod, 1991). It should be noted that the increase in beds in public hospitals and universities was considerably under the population increase for the period; the absolute increase was actually a relative decrease, resulting in a net increase in patient density.[3] This pattern follows the neoliberal logic of the HTP.

The present research has confirmed such an inclination toward private hospitals. However, it has also shown that the public healthcare schema continues to be the central pillar of the Turkish healthcare system in terms of participant preference. This preference was mainly based on the provision of economical services in public hospitals. The positive correlation between per capita income and private hospital preference also shows that service quality and speedy access to service come to play a significant role in the choices made by people (the public as health service users or "consumers").

It should be noted that a good quality of service cannot be seen as a distinctive feature of private hospitals (run as enterprises) since both the (non-profit) university and training and research hospitals were also reported to provide a satisfactorily quality service (Table 3). The point that distinguished the latter two types of hospitals from the others was that of trust. This is likely to depend on the academic rank of their doctors. In other words, the speedy availability of service was the only outstanding characteristic of private hospitals.

The fact that the public-owned institutions remain the backbone of the health system is also pertinent for other middle-income countries that have initiated the neoliberal transformation process. For example, Chile was presented by the World Bank as an example of a country that had implemented a successful neoliberal health reform (Berkley et al., 1993; Unger, De Paepe, Cantuarias and Herrera, 2008, p. 542). However, it is argued that the

[3] 2002-18 beds increase in public and university hospitals 19%; population increase 26%; population figures from the World Bank (2022).

relative success of the Chilean healthcare system "has been achieved despite the reform, not because of it, or in fact, because the intended neoliberal reform could not be implemented as foreseen" (Unger et al., 2008, p. 546). Parallel to the drastic reduction in healthcare funding, there was a restriction in the supply of public healthcare services (Koch, Cid Pedraza and Schmid, 2017; Unger et al., 2008, p. 543). Therefore, after two and a half decades of its implementation, Chile initiated a new health reform plan in 2005 for better quality and shorter waiting times in public-owned healthcare facilities (Núñez, Manzano and Chi, 2020; Rotarou and Sakellariou, 2017; Unger et al., 2008).

Similar to the Chilean case, the findings of this research indicate that the Turkish model requires another reform, especially in the supply of public healthcare services, as high patient density is the most crucial problem experienced. High patient density results in relatively long waiting times, difficult access to timely attention, and low-quality services, finally leading to patients being compelled to use private hospitals. In the Turkish case as reported here, this compulsion is more explicitly seen in dental and ophthalmic treatments. The fact that only 32% of dentists are affiliated with the Ministry of Health confirms that private hospitals and practices are predominant in dental treatment (Turkish Dental Association, 2019, p. 1). In the treatment of eye-related problems, SSI-contracted private ophthalmology hospitals or centres might be preferred because they offer affordable treatment packages. However, when it comes to surgeries and cancer treatments, the participants may prefer public-owned hospitals to avoid high costs and catastrophic expenditures.

When we evaluate the reason for hospital type preference and the problems with the healthcare system together, we see that the economic determinants prevail over and directly influence the others: The high density in public-owned hospitals stems from economic reasons, and it also leads to poor-quality service and people having to use private hospitals. This vicious circle can be broken by investing in the public health system. To this end, in the light of the findings reported here, it would follow that policymakers need to develop a new reform agenda to cope with the high patient density in public hospitals. This would be advised politically, too, since the issue of health provisioning and healthcare policies are very influential in voter preferences and thus of great importance in terms of political competition. Continued adherence to the neoliberal spirit of the HTP can be expected to lead to incompetence, a failure to overcome the developing health-economic crisis and, thus, to the incapacity of the public healthcare system in Turkey to provide for the wellbeing of its citizens.

In this context, first, the supply of public healthcare should be increased by augmenting the number and capacity of public-owned hospitals rather than transferring funds to the private sector. Second, we suggest, more attention should be paid to public health by attaching importance to preventive health services. Third, the implementation of the referral chain is of vital significance, together with improving primary care and reducing the population dependent on a family physician (Bektemur, Arıca and Gençer, 2018; Bulut and Uğurluoğlu, 2018). This step would increase the allocative efficiency of the health system (Belek, 2016, p. 97). As this research has shown, low levels of trust, poor quality and less friendly services and short inspection times prevent family practice units from assuming the role of gatekeeping (Table 3). Therefore, without overcoming the problems in primary care, it will not be possible to ease the burdens facing hospitals.

Finally, despite the gradual improvement of access to healthcare via the introduction of the GHI system, a critical portion of the population still declares an unmet need for medical care due to cost or availability (Yardim and Uner, 2018). Adjusting co-payments with a referral system should offer relief to lower-income groups, which have been negatively

affected by the rising trend of out-of-pocket expenditures (Cinaroglu, 2017, p. 39).

Along with these policy recommendations, the limitations of this research may inspire future research regarding the issues addressed here. Two main limitations may be mentioned. First, the Istanbul City Hospital, which was built with a public-private partnership, was not yet operational during the field study, and this was thus not included among the hospital types. Although the Turkish government ended the construction of new city hospitals using this model due to their burden on the national budget, these hospitals were added to the health system as a new hospital model. This new type of hospital is critical concerning the privatisation of healthcare, and future studies should take it into consideration.

Second, this research focused on secondary care. However, any analysis of the issues will remain incomplete without elaboration on primary care. A more holistic scope for future studies should provide a comprehensive examination of the challenges facing the Turkish health system.

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Ethics Approval Statement

With decision no 2019/1, the study received ethical approval from the Human Subjects Ethics Committee of the Istanbul Yeni Yuzyil University in the meeting held on 7 January 2019 in Istanbul, Turkey. All procedures performed in studies involving human participants were in accordance with the ethical standards. Informed consent was obtained from all individual participants included in the study.