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Universal Health Coverage with Private Options: The Politics of Turkey's 2008 Health Reform

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Abstract

Over the past decades, countries across the Global South have been adopting expansionary health reforms and are increasingly doing so under the banner of promoting universal health coverage. But countries have taken notably different approaches regarding the inclusion of private actors in their expanding healthcare systems. In this article, we explore the political causes and consequences of partial privatization in the context of healthcare expansion. We conduct a case study of Turkey's 2008 health reform, which coupled substantial coverage expansion with the introduction of private options in provision and financing—and has since been branded as a global "success story" of achieving universal health coverage. Specifically, we seek to explain why Turkey introduced private options with its expansionary health reform and what kind of policy feedback effects this has triggered. We find that private options were incorporated into the reform as the result of persistent business lobbying and pro-market changes in the leadership of the health ministry and not because of any international coercion, e.g., by the World Bank. The introduction of these private options has since led to the growth of private hospital and insurance markets and the political entrenchment of partial privatization.

Keywords Healthcare · Private options · Privatization · Universal health coverage · Turkey

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Introduction

Over the past two decades, universal health coverage (UHC) has become an increasingly explicit global policy norm (see Fillol et al. 2021; Kaasch 2015).[1] In 2011, the World Health Assembly passed a resolution that recognized the importance of achieving "universal health coverage" by "providing comprehensive health care and services for all" (Source 01, abbreviated S01).[2] In 2012, the United Nations General Assembly underlined "the responsibility of Governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services" (S02). In 2015, the goal of universal health coverage was enshrined in the Sustainable Development Goals (SDGs) of the United Nations. SDG target 3.8 aims to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (S03). Crucially, the promotion of universal health coverage as a policy norm has gone beyond the WHO and the UN and has also taken root in traditionally more neoliberal international organizations. In 2014, the World Bank president Jim Yong Kim declared that "achieving universal health coverage and equity in health are central to reaching the [World Bank's] global goals to end extreme poverty by 2030 and boost shared prosperity" (S04).

Despite this broad normative consensus on the goal of universal health coverage, disagreement and political conflict persists as to how it should best be realized (Greer and Méndez 2015). One of the most contentious debates in this context has been about the role of private actors in healthcare systems across the Global South. Privatization proposals have been central elements of most healthcare reforms in low- and middle-income countries ever since the heyday of the Washington Consensus (de Carvalho 2022; Noy 2017). For example, many countries have allowed private health insurance providers to compete with public providers or made private healthcare service providers eligible for public reimbursement (Vargas Bustamante and Méndez 2014). International financial institutions such as the World Bank have been key proponents of privatization in healthcare, arguing that it can increase healthcare system efficiency and investments (de Carvalho 2022; Noy 2017; Weyland 2006). Many social scientists have doubted these efficiency gains (Basu et al. 2012) and highlighted that privatization processes often lead to healthcare system segmentation and eventually health inequalities (Bernales-Baksai 2020; Birn et al. 2016; Kumar and Birn 2018; Vargas Bustamante and Méndez 2014; Yilmaz 2013).

Despite the significant socioeconomic consequences of privatization, we still know relatively little about the politics of healthcare privatization, especially during the recent wave of universalizing healthcare reforms in the Global South. To contribute to a better understanding of the political causes and consequences of

[1] While the specific concept of "universal health coverage" is relatively new, it draws on various earlier ideas, in particular "Health for All," a global health policy goal developed during the 1970s (see Lawn et al. 2008). On the analytical concept of "policy norms," see Park and Vetterlein (2010).

[2] Complete references to all our primary sources can be found in the online Appendix.

healthcare privatization, this article analyzes the case of Turkey. Turkey's 2008 health reform offers a compelling case study, as it achieved significant progress toward universal healthcare but also partially privatized hospital and health insurance markets (Agartan 2012; Yilmaz 2013).[3] International organizations have since framed and promoted Turkey's health reform as a "success story" of achieving universal health coverage (Agartan 2021). The World Bank in particular was an early supporter of Turkey's health reform, both in financial and ideational terms. We will show, however, that the partial privatization of the Turkish healthcare system was the result of primarily domestic political dynamics, notably lobbying efforts by the private hospital and insurance industries.

The Political Causes and Consequences of Healthcare Privatization in the Global South

Even though the debate about the nature of the socioeconomic consequences of healthcare privatization is far from settled (see Basu et al. 2012), there is little doubt on either side of the debate *that* healthcare privatization is very consequential. It is therefore important to better understand the politics of healthcare privatization in the Global South. Given that full healthcare privatization has been extremely rare, the central issue is the introduction of *private options* in healthcare provision and financing. In the following, we review the existing literature, focusing first on the political causes of initial healthcare privatization reforms and then on the political consequences (or feedback effects) of privatization for subsequent reform dynamics.

Political Causes of Healthcare Privatization

While privatization seems omnipresent in the literature on health reforms in the Global South, its political causes are seldom theorized and investigated explicitly. That being said, the existing literature has identified concentration of government power (often higher in authoritarian regimes), neoliberal government ideology, and the absence of influential veto players, as well as dependence on international financial institutions as drivers of healthcare privatization. These explanations can be grouped in two broad camps: those highlighting domestic political dynamics and those emphasizing international influences.

A natural starting point for any theoretical discussion of the causes of healthcare privatization is the case of Chile. The country underwent radical neoliberal restructuring during the dictatorship of Augusto Pinochet. However, and in contrast to other policy areas such as education and pensions, (even) Chile only introduced

[3] In the literature on Turkey's health reform, it has so far not been customary to assign a specific year to this reform, likely because the AKP began gradually rolling out its "Health Transformation Program" in 2003 (see Agartan 2012, 463). This article pragmatically speaks of Turkey's "2008 health reform," as all major changes regarding Turkey's new health insurance system were institutionalized with the Social Security and Universal Health Insurance Law passed in 2008.

partial rather than full privatization of its healthcare system. In 1981, Chile partially privatized health insurance markets by allowing workers to choose between a public and various private health insurance funds. Rossana Castiglioni's (2001) account of Chile's 1981 health reform represents one of the most complete theoretical explanations of healthcare privatization. Accordingly, healthcare privatization was the result of an increasing concentration of power, both of Pinochet within the government junta and of a small group of economic technocrats, known as the Chicago Boys, within the state bureaucracy, as well as the neoliberal ideology of those newly empowered technocrats (Castiglioni 2001, 47–56).[4] While this concentration of power was clearly linked to the nature of Chile's political regime at the time, not all dictatorships become similar agents of privatization (Castiglioni 2001, 37). The fact that healthcare privatization in Chile was only partial has been attributed to the influence of Chile's professional medical association as a veto player in this process (Castiglioni 2001, 58–61).

Another influential line of research has identified policy prescriptions from international financial institutions, notably the World Bank and the International Monetary Fund (IMF), as a source of healthcare privatization in the Global South (see Armada et al. 2001; Kumar 2019; Noy 2015, 2017; Tichenor and Sridhar 2017).[5] In Tanzania, for instance, a 1986 structural adjustment program with the IMF and the World Bank led to severe budget cuts and retrenchment of public healthcare services, which in turn motivated the partial privatization of both healthcare provision and financing during the early 1990s (Sadock and Veit 2021, 19–21). Similarly, Colombia's 1993 health reform led to substantial privatization of healthcare financing and service provision, which was in line with central prescriptions of the Washington Consensus, in particular the World Bank's 1987 report on "Financing Health Services in Developing Countries" (de Carvalho and Frisina Doetter 2022, 215). This perspective is of particular relevance for our case study analysis, as the World Bank was closely involved in Turkey's 2008 health reform (Yilmaz 2017, 126–129).

Political Consequences of Healthcare Privatization

The second major dimension of the politics of healthcare privatization concerns its political consequences. Building on theories of policy feedback (Béland and Schlager 2019; Busemeyer et al. 2021; Hacker 2002; Jacobs and Weaver 2015; Pierson 1993) and their foundational dictum that "policies shape politics" (Béland et al. 2022), health policy scholars have explored the ways in which healthcare privatization can reshape health politics. Disagreement persists, however, on the direction of these feedback effects, that is, the question if healthcare privatization tends to be self-reinforcing or self-undermining.

[4] A similar combination of highly concentrated political power and influential neoliberal ideology also helps explain China's post-1978 healthcare system privatization—which has, however, been largely reversed since the 2000s (Yip and Hsiao 2015).

[5] More recently, it has also been suggested that involvement by the Gates Foundation has contributed to healthcare privatization in the Global South (McCoy and McGoey 2011, 152).

The arguably dominant perspective in this literature has been that healthcare privatization creates path dependence and thus becomes politically self-reinforcing. Path dependence can be the result of different mechanisms, namely, the reconfiguration of interest groups and of public opinion. To begin with, privatization creates powerful new interest groups, notably private health insurance providers and private hospitals, which become influential opponents of any potential policy reversal (Ewig and Kay 2011; Harris and Libardi Maia 2021). In fact, private health insurers and providers tend to become advocates of further privatization measures, for example, through the introduction of public subsidies in support of private demand (Dorlach 2021, 298), constituting an "accelerating" rather than merely "self-reinforcing" feedback effect (see Busemeyer et al. 2021).

Another self-reinforcing feedback mechanism that can lock in healthcare privatization is broadly attitudinal and relates to the "public goods trap" outlined by Fernando Filgueira (2013, 43). If private alternatives to public services exist, in healthcare for example, and if the relative quality of public services deteriorates, then social groups that can afford it—usually the upper-middle and upper classes—will voluntarily exit the public system. This exit of quality-demanding and politically influential elites reduces pressure for high-quality public services, potentially creating a vicious cycle of elite exit and quality differentiation. This dynamic has manifested itself in the distinct segmentation that characterizes healthcare systems across the Global South (Bernales-Baksai 2020; Martínez Franzoni and Sánchez-Ancochea 2018). Extending this logic, one can assume that elites would strongly oppose any elimination or even restriction of private options that would require them to return to lower-quality public healthcare institutions (see Busemeyer and Iversen 2020), thus making a potential reversal of healthcare privatization politically much more difficult.

An alternative perspective on policy feedback suggests that healthcare privatization can also lead to discontent, protest, and ultimately policy reversal. Adopting such a "self-undermining" policy feedback perspective (see Jacobs and Weaver 2015), Wireko and colleagues (2020) study the privatization of healthcare financing in Ghana during the 1970s and 1980s through the introduction of various user fees as part of a so-called "cash-and-carry" policy. They trace how this privatization of financing led to reduced access to healthcare and severe financial hardship for both healthcare users and providers. These feedback effects "made the cash-and-carry policy increasingly unpopular and unacceptable" and thus created a "window of opportunity" for the abolition of user fees and the introduction of a national health insurance system (Wireko et al. 2020, 1152–1156). Drawing on Karl Polanyi's theory of the "double movement" (see Dale 2012), Wang (2010, 257–258) provides a very similar analysis of the Chinese case, arguing that the "market-oriented reforms of the 1980s and 1990s gradually shattered the country's social safety nets, including its once famous healthcare system, making it difficult for many rural and urban residents to afford treatment," which has since led to a "protective counter-movement" and the restoration of an "affordable and equitable healthcare system."

Notably, healthcare privatization can also trigger both self-reinforcing *and* self-undermining feedback mechanisms. This dual dynamic can be witnessed in Chile. Ever since Chile's return to democracy in 1990, there have been attempts to reverse

the privatization of the country's healthcare system. Privatization, however, has created powerful new interests, most notably those of the newly established private health insurance funds, which have so far successfully prevented any significant reversal of privatization, especially during a reform window in the early 2000s (Ewig and Kay 2011, 82–83). At the same time, discontent with the country's partially privatized and deeply segmented healthcare system has been a key demand of the massive protests that erupted in Chile in 2019 (Bossert and Villalobos Dintrans 2020). In response to this social unrest, Chile convened a constitutional assembly, which drafted a new constitution that would have (among many other things) substantially reversed healthcare privatization by making public health insurance mandatory and private health insurance merely supplementary (S05). While this draft constitution was rejected in a popular referendum in September 2022, the Chilean case illustrates that healthcare privatization can also have feedback effects that are both self-reinforcing and self-undermining at the same time.

Case Selection and Research Design

To explore the political causes and consequences of healthcare privatization, especially in the context of the recent expansion of healthcare coverage across the Global South, we conduct a case study of Turkey's 2008 health reform. Turkey had a statist but "truncated" (Holland 2018) and highly fragmented healthcare system when it passed a major health insurance reform in 2008 (Agartan 2015; Buğra and Keyder 2006). This reform has since become a global "success story," promoted by international organizations for emulation by other countries (Agartan 2021), and its expansionary dimension has attracted significant attention in the comparative health policy literature (Harris 2019; Sparkes et al. 2019a, b). Central for our analytic purposes, Turkey's health reform coupled the expansion of healthcare coverage with the introduction of significant private options in both healthcare provision and financing. In terms of policy sectors, we focus on Turkey's hospital and health insurance markets. These two were the primary healthcare markets in which private options were introduced. This comparative sectoral analysis allows us to go beyond the respective particularities of the two policy areas and to examine their interdependence and "coevolution" (Trein 2017).

To explain why substantial private options were introduced as part of Turkey's expansionary health reform, and what political consequences this policy change has had, we inductively trace the political processes that led to and from this reform. Inductive process tracing is an ideal method for studying the causes and consequences of specific outcomes and for theory building (Trampusch and Palier 2016, 443–445). Our qualitative process tracing analysis draws on data collected during field research conducted in Turkey between 2019 and 2022. It should be noted that Turkey's recent authoritarian turn (see Esen and Gumuscu 2016), particularly since the failed coup attempt of 2016, complicated our fieldwork, especially the recruitment of interviewees among current, AKP-aligned bureaucrats and politicians. On the other hand, our analysis benefited from extensive media coverage of the health reform process during a time period (the 2000s and early 2010s) when

Turkish media was still relatively more independent from the AKP government (see Yeşil 2018). Our process tracing analysis is thus primarily based on news reports, laws, and regulations as well as anonymous in-depth interviews with former health bureaucrats and informants in the hospital and insurances industries. To make our data sources and analysis more transparent (see Moravcsik 2014), we present complete references to all our textual primary sources, together with more detailed information on the conducted interviews, in the online Appendix.

Turkey's 2008 Health Reform: An Overview

Turkey's 2008 health reform, the centerpiece of the country's 2003 Health Transformation Program, was formulated, adopted, and implemented, during the first two terms in power (2002–2007, 2007–2011) of Recep Tayyip Erdoğan's conservative Justice and Development Party (*Adalet ve Kalkınma Partisi*, AKP).[6] Since its introduction, Turkey's health reform has been described as a "revolution in health" (Horton and Lo 2013) and become a poster child of the World Bank (Agartan 2021), resulting in both a universalization and marketization of the Turkish healthcare system (Agartan 2012). In the following, we briefly outline these two transformations and sketch the broad reform process.

Universalization and Marketization

One of the most important outcomes of Turkey's 2008 health reform has been the universalization of access to healthcare, involving a massive expansion of population coverage and increased benefit generosity, as well as the unification of public healthcare insurance funds and their respective benefit packages. Health insurance enrollment became mandatory and increased from 67% of the Turkish population in 2002 (Agartan 2012, 464) to 88% in 2021 (infra Table 2). Means-tested non-contributory health insurance for the poor, known as the Green Card program, substantially expanded in both coverage and generosity. Indeed, Turkey has been one of six countries worldwide that made the biggest improvements toward Universal Health Coverage between 2000 and 2016 (Fullman et al. 2017, 1433). The reform not only expanded but also unified access to public healthcare, previously segmented along occupational lines (Sparkes et al. 2015, 265; Yilmaz 2013). Several existing health insurance funds were merged into one single-payer public fund, the Social Security Institution (*Sosyal Güvenlik Kurumu*, SGK), which, since 2008, operates Turkey's Universal Health Insurance (*Genel Sağlık Sigortası*, GSS) scheme.

Despite the progress, healthcare universalization in Turkey remains incomplete. To begin with, access to public healthcare depends on the regular payment of health insurance contributions and is therefore not an unconditional right. A significant number of people—recent estimates suggest between 6 and 10 million (S06)—are

[6] On the broader transformation of the Turkish welfare state during the AKP era, see Buğra (2020), Dorlach (2015), and Yörük (2022).

regularly left without access to public healthcare due to outstanding premium debt. Relatedly, not all poor households that in theory should be eligible for non-contributory health insurance qualify for the program in practice, creating significant financial hardship in the form of either mandatory monthly insurance contributions or huge out-of-pocket payments in case of sickness (Erus et al. 2015). While Turkey might therefore have gotten much closer to the goal of universal health coverage, defined by the WHO as a situation in which "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship" (S07), it clearly has not yet fully achieved it.

Turkey's health reform has also involved comprehensive marketization. One manifestation of this, and indeed the main concern of this article, has been the partial privatization of healthcare provision and financing through the introduction of private options. In healthcare provision, public insurees can now choose to receive treatment in one of the many private hospitals that have a cooperation agreement with the SGK (see Yilmaz 2021a). These private hospitals, however, can (and generally do) charge patients additional fees (*ilave ücretleri*) up to a certain legally defined percentage of the reimbursement price they receive from the SGK for each treatment. In healthcare financing, enrollment in the SGK's universal health insurance scheme is mandatory for all adult Turkish citizens, but public insurees can purchase supplementary health insurance (*tamamlayıcı sağlık sigortası*) plans from private providers to cover services not included in the SGK's basic benefit package (*temel teminat paketi*), such as the above-mentioned additional fees charged by private hospitals (Erdoğan 2020).[7] The introduction of these private options has resulted in a segmented healthcare system, in which poorer households have to settle for the "basic universalism" provided by public health insurance, while wealthier households systematically pay extra to receive better care from private healthcare providers (Yilmaz 2013). Table 1 summarizes the reforms that have led to the gradual institutionalization of "segmented universalism" (see Noy 2018, 178) in Turkish healthcare. Explaining the political causes and consequences of this process is the main purpose of this article.

The marketization of Turkey's healthcare system has gone beyond the creation of private options. For instance, there has also been a strong emphasis on the use of public–private partnerships in the construction and operation of large-scale hospital complexes, known as "city hospitals" (Pala et al. 2018). Furthermore, the Turkish government has pursued a strategy of turning Turkey into a medical tourism destination to create an export market for healthcare services (Yilmaz and Aktas 2021). Public hospitals, too, have undergone a process of marketization, as they have become autonomous units and introduced performance-based pay systems (Agartan 2012). Finally, Turkey's previously highly segmented and untransparent pharmaceutical market was integrated and reregulated (Dorlach 2016). Most of these marketization processes have followed the rationale of efficiency enhancement and

[7] Anyone living in Turkey remains free to purchase primary private health insurance, but this does not relieve Turkish citizens from the requirement to pay for public health insurance.

Table 1 Key reforms during the partial privatization of Turkey's healthcare system

Policy measure	Relevance for privatization
Health Transformation Program (2003)	A report published by the AKP government that outlined its broader health reform agenda, including the universalization of health insurance and the marketization of healthcare provision
Law 5510, Social Security and Universal Health Insurance Law (2006)	Entering into force in 2008, the law restructured and expanded health insurance by unifying public social insurance funds and creating a single-payer social security system (SGK). This law notably included no provisions on private options in healthcare provision or financing
Law 5754 (2008)	Amended Law 5510 (2006) to provide that the permissible level of additional fees chargeable by private hospitals can be set by the Council of Ministers at up to 100% of the SGK reimbursement price. Amended Law 5510 (2006) to grant the Undersecretariat of Treasury the authority to later introduce supplementary health insurance
Ministry of Health Regulation on Private Health Institutions and Private Hospitals (2008/26788) (2008)	Authorized the health ministry to develop plans for both the public and private sectors regarding health institutions and the related health workforce, medical service units and qualifications, and technology-intensive medical device distribution
Ministry of Health Regulation on Private Hospitals (2008/26788) (2008)	Introduced the requirement of health ministry approval for the building of new or expansion of existing private hospitals. Later dubbed by the private sector as the "15 February earthquake"
Council of Ministers Decree 2008/13728 (2008)	Set the initial cap on additional fees chargeable by private hospitals at 30% of the SGK reimbursement price
Council of Ministers Decree 2009/15627 (2009)	Raised the cap on additional fees chargeable by private hospitals to 70% of the SGK reimbursement price
Council of Ministers Decree 2012/2939 (2012)	Raised the cap on additional fees chargeable by private hospitals to 90% of the SGK reimbursement price
Law 6486 (2013)	Amended Law 5510 (2006) to provide that the permissible level of additional fees chargeable by private hospitals can be set by the Council of Ministers at up to 200% of the SGK reimbursement price
Prime Ministry (Treasury) Regulation on Private Health Insurance (2013/28800) (2013)	As authorized by Law 5754 (2008), the Undersecretariat of Treasury introduced procedures and principles that implemented supplementary health insurance
Council of Ministers Decree 2013/5385 (2013)	Raised the cap on additional fees chargeable by private hospitals to 200% of the SGK reimbursement price

Source: authors' compilation

cost containment, while often also creating new business opportunities for private investors (see Dorlach 2015, 536).

This dual transformation of the Turkish healthcare system, involving both universalization and marketization, has arguably had substantial effects on health outcomes as well as patient satisfaction. While there is relatively broad agreement that key health outcomes, e.g., the country's infant mortality rate, have improved over the past two decades (see Ökem and Çakar 2015), disagreement persists over the extent of these improvements and the degree to which they have been causally related to the AKP's health reform (Atun et al. 2013; Cesur et al. 2017; Hamzaoglu 2020). As regards patient satisfaction, the expansion of healthcare coverage proved to be highly popular (Hazama 2015; Sparkes et al. 2019a, 2019b), at least initially, and has been considered as a key contributing factor to the AKP's first two reelection victories in 2007 and 2011 (Dorlach 2016, 72–73; Öniş 2012, 141–142). On the other hand, the marketization of healthcare, and the partial privatization of the hospital market in particular, has led to "heterogenous" patient experiences, "ranging from problem-free experiences to unfulfilled high expectations raised by populist discourses and demands for informal payments" (Yilmaz 2021a, 602; see Kesici and Yilmaz 2023). More recent reports suggest that patient satisfaction with Turkey's healthcare system might be falling, especially in the context of a health sector brain drain and a broader cost-of-living crisis (S08, S09).

Political Origins and Processes

Turkey's introduction of health insurance reform can be attributed to the ascension to power of a party with high political commitment to health policy change in a favorable environment. The 2002 electoral victory of the Islamic-conservative but market-liberal AKP was a watershed moment in Turkish politics. During its early years in power, the AKP faced intense electoral competition and was thus especially eager to introduce reforms that would broaden its electoral appeal (Öniş 2012).[8] In this context, health coverage expansion became one of the central political promises of the AKP government (S10). In formulating the 2008 health reform, the AKP was able to draw on policy ideas developed during the 1990s, both nationally and internationally (Agartan 2015). It was able to adopt such a large-scale reform because it enjoyed absolute parliamentary majorities throughout the reform period and because it was able to overpower extra-parliamentary opposition, e.g., from the Turkish Medical Association (Yilmaz 2017, 178–189). The AKP's reform project also benefited from support from the World Bank, the IMF, and Turkey's largest employer association (TÜSIAD).

It is important for our subsequent analysis to briefly sketch the political process through which this health reform was adopted. Given its political salience, the AKP had initially planned to submit a separate health reform bill to parliament (S11). But it soon decided to combine a relatively popular health reform with a much less

[8] On the broader relationship between democratization, electoral competition, and health coverage expansion, see, for instance, Aspinall (2014) and Grépin and Dionne (2013).

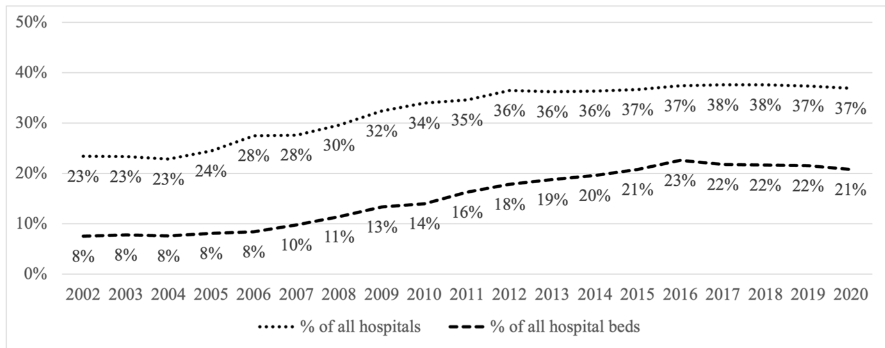

Fig. 1 Market share of private hospitals in Turkey, 2002–2020 (source: Ministry of Health (S36))

popular pension reform, so that the prospect of health coverage expansion could function as a "sweetener" for significant pension cuts (S12). Indeed, the merged Social Security and Universal Health Insurance Law successfully passed parliament in 2006 (S13). But it was then vetoed by the Turkish president and partially annulled by the Constitutional Court, requiring a revision of the law.[9] While the Constitutional Court's concerns were about the law's pension system changes, health sector interest groups used this window of opportunity to successfully push for amendments to the law's health insurance component. Turkey's parliament amended and finalized the Social Security and Universal Health Insurance Law in 2008 (S14), thus establishing the system's "foundational policy architecture" (Martínez Franzoni and Sánchez-Ancochea 2016). Our analysis will demonstrate that this relatively opaque revision process from 2006 to 2008 resulted—through the legislative back door—in the inclusion of private options in Turkey's universal health insurance reform.

Lobbying and Ideology in the Introduction of Private Options

While the broader politics of Turkey's health reform has been studied extensively (see Yilmaz 2017, 2021c), important questions about the formulation and adoption of this landmark reform remain unanswered. For instance, it remains unclear why policymakers decided to introduce private options in healthcare provision and financing and if universalization without privatization was ever seriously considered. To answer these questions, this section traces the political origins of the partial privatization of Turkey's hospital and health insurance markets. In a nutshell, we find that significant private options were included in the reform project only after

[9] Under Turkey's political system of the time, the president had the power to veto laws and send them for judicial review to the Constitutional Court. The 2017 constitutional reform has since replaced this parliamentary with a presidential system (see Yeğen 2018).

persistent lobbying from organized business during a period of low public attention, and they were only fully implemented after the 2013 departure of health minister Recep Akdağ. This analysis demonstrates that the introduction of private options is by no means a necessary component of Universal Health Coverage reforms but the result of a political struggle between different interests and ideas.

Establishment of an Internal Market for Healthcare Provision

Until the early 2000s, Turkey's private hospital sector remained relatively small. In 2002, private hospitals made up for 23% of all hospitals but provided only 8% of total bed capacity (see infra Fig. 1), suggesting that private hospitals were relatively small or focused on outpatient services. Unsurprisingly, private hospitals were used disproportionality by higher-income households and households with (full) private health insurance (Adaman et al. 2009).

One major objective of the AKP's health reform was to increase healthcare system efficiency through the establishment of an internal market for healthcare provision (Yilmaz 2021a), which would allow both public and private hospitals to receive public reimbursement for treating public insurees. The original intention of the reform team—led by the Ministry of Health and the SGK—was to establish competition between public and private hospitals solely on the basis of the SGK's reimbursement prices, that is, without any additional fees chargeable by private hospitals. Indeed, the first version of the Social Security and Universal Health Insurance Law, legislated in 2006, did not permit hospitals to charge public insurees any additional fees—except for "hotel services" and chief physician treatment (S15). If private hospitals did not want to treat public insurees at SGK's reimbursement prices, they would be ineligible for any public reimbursement and have to limit themselves to self-paying private patients. The reform team accepted that wealthier households, around 10% of the population, would go to such fully private hospitals and thus effectively opt out of the financial reimbursement provided by public health insurance but expected to be able to reach about 90% of the population through the publicly financed system (Interview 5, abbreviated I5).

However, as discussed above, the Social Security and Universal Health Insurance Law as passed in 2006 was partially annulled by the Constitutional Court. This led parliament to amend various aspects of the law, including aspects that had not been contested by the court, such as the issue of additional fees chargeable by private hospitals. This revision process began a few months after the AKP's decisive reelection in July 2007 (Öniş 2012, 137) and thus at a time when any potential public backlash would have carried limited political cost.

During the amendment process, the health reform team gave up its maximalist position that private hospitals should be forbidden to charge public insurees any additional fees, but it maintained that additional fees should be marginal. According to the revised bill that passed parliamentary committees, private hospitals would be permitted to charge public insurees additional fees of up to 20% of the SGK reimbursement price (S16). Health minister Akdağ explained at the time that "citizens should not make significant payments beyond the amount reimbursed by SGK. Contributions around 10% to 20% are possible. But let's assume that SGK paid one thousand Lira to a private

hospital for a service it provided. And then that private hospital wants to charge you an additional one thousand Lira. It is obvious that such an approach is unacceptable both from the citizens' perspective and from our perspective" (S17).

The reform team's vision of the role of private hospitals in Turkey's healthcare system was further clarified by the Undersecretary of Health, Sabahattin Aydın, in January 2008: "If the health sector today is profitable, it is because it is out of control. In the long run there will be no profit [in the health sector]. For the private sector to continue investing in the area of health, it will need to think of hospitals as social responsibility projects, rather than as a way to make profit. Otherwise, these [private sector] institutions will in the long run not find what they are looking for" (S18). This demonstrates that the reform team originally envisioned comprehensive marketization but only very limited privatization of healthcare delivery.

Unsurprisingly, the private hospital industry strongly opposed this original vision of the reform. Both the (vetoed) 2006 law and the 2007 draft bill would have basically made it unprofitable to operate private hospitals targeting public insurees. Industry representatives were deeply concerned over how much business would be left for private hospitals (I5). They argued, not without merit, that it would be "impossible" for private hospitals to reduce their prices to the level of state-subsidized public hospitals and that they would not sign an agreement with the SGK if they were not allowed to charge additional fees. This would have capped the growth potential of the private hospital sector (S19). Private hospitals' position also did not change in response to the 20% additional fees proposed by the 2007 draft bill (S20, S21). The private hospital industry actively advocated for a deregulation of chargeable additional fees. Represented by the Private Hospital and Healthcare Provider Association (*Özel Hastaneler ve Sağlık Kuruluşları Derneği*, OHSAD), as well as the health sector assembly of the Union of Chambers and Commodity Exchanges of Turkey (*Türkiye Odalar ve Borsalar Birliği*, TOBB), the hospital industry told journalists that it would do whatever necessary "to change the ministry's course of action" (S22).

After the reform team's 20% proposal had made it through all relevant parliamentary committees, it was challenged during its final plenary hearing in parliament in spring 2008, when a group of parliamentarians from the ruling AKP successfully motioned to relax the paragraph (S23). The revised law, legislated in April 2008, mandated that the level of additional fees chargeable by private hospitals is to be set by an inter-ministerial commission, within the range of 0% and 100%. In September 2008, this level was initially set at 30%, just slightly above the health reform team's 20% proposal (S24). Nevertheless, this last-minute amendment still represented a major victory for the private hospital industry, as it left the issue of additional fees practically unresolved and delegated authority over it to future executive decisions. Moreover, additional fees of 30% already created some room for the development of private sector activity in Turkey's new internal market for healthcare provision.

Introduction of Supplementary Health Insurance

Universal health insurance enrollment was at the core of the AKP's health reform project and an almost universally shared goal during the reform process. It was

also widely accepted that mandatory primary health insurance would be public. To be clear, the private insurance sector would have preferred a system like Chile's or Germany's, which allow (some) workers to opt out of the public system by purchasing private health insurance. But this policy option was not seriously discussed in the early 2000s. Even TÜSIAD's 2004 health reform proposal, whose lead author was an insurance sector consultant, did not propose the outright introduction of private primary health insurance but only proposed this as a potential future option *after* the implementation of universal public health insurance (S25). The World Bank, which is usually viewed as a proponent of health system privatization (see de Carvalho 2022; Noy 2017), even explicitly argued *against* a "significant role for private health insurance" (S26). Mandatory public health insurance was therefore largely uncontested.

What was contested, however, was the available room for private health insurance schemes *beyond* the SGK's basic benefit package. The main question was if private insurance companies would be allowed to offer supplementary health insurance plans that public insurees could purchase to cover services and costs outside the SGK's basic benefit package, such as the above-discussed additional fees charged by private hospitals. While supplementary health insurance has long been common in countries like Germany and the Netherlands, and was therefore hardly a radical policy proposal, it tends to stratify healthcare systems and can create pressure on the generosity of the benefit package of public health insurance (Yilmaz 2013, 72–73).

The insurance industry, represented by the Insurance Association of Turkey (*Türkiye Sigorta Birliği*, TSB), had a strong preference for the introduction of supplementary health insurance, so as to create a market for a new insurance product. In 2003, when the government began working on the details of its health reform, industry associations representing the insurance industry and private healthcare providers sponsored the preparation of a 52-page policy proposal on supplementary health insurance by a private sector expert group, which strategically presented supplementary health insurance as a tool for controlling the emerging financial pressure on public health insurance (S27). The private hospital industry joined the insurance industry in advocating for private supplementary health insurance because the additional fees that private hospitals wanted to charge SGK insurees were to be among the items to be covered by it, thus promising to boost demand for private hospital services.

Initially, however, policymakers plainly rejected the industry's supplementary health insurance proposal. Industry representatives had the opportunity to present their policy proposal directly to health minister Recep Akdağ in January 2004. But Akdağ, who had a very statist mindset, did not like the idea of supplementary health insurance, worrying that it could increase the share of private health financing and dilute public satisfaction with health policy. Akdağ was not the only critic of supplementary health insurance. The SGK's inaugural president, Tuncay Teksöz, also emphatically opposed the idea. A common argument made by these bureaucrats was that, if the SGK's benefit package was in any way incomplete, then it should be expanded rather than privately supplemented (S28). With two vocal opponents in charge of the health ministry and the SGK, supplementary health insurance was notably absent from the health insurance law passed in 2006.

A second window of opportunity for introducing supplementary health insurance opened during the 2007–2008 revision of the Social Security and Universal Health Insurance Law. The insurance industry successfully lobbied high-ranking AKP members on the parliamentary health committee to support the cause of supplementary health insurance (I6). These then introduced an amendment that granted the Undersecretariat of Treasury (*hazine müsteşarlığı*) the authority to later introduce supplementary health insurance (S29). This last-minute change was facilitated by the resignation of Tuncay Teksöz as SGK president in September 2006 (S30, I6).

Turkey's Social Security and Universal Health Insurance Law of 2008 therefore left the door open for the introduction of supplementary health insurance by the Treasury. The latter had long viewed supplementary health insurance favorably, given its potential to take pressure of the government budget. From 2004 to 2008, the Treasury had already convened a special commission, headed by a health insurance industry consultant, to develop a detailed proposal on supplementary health insurance. However, health minister Akdağ continued to resist the implementation of supplementary health insurance throughout his time in office. Only after Akdağ was replaced by Müezzinoğlu in 2013 did the Treasury implement supplementary health insurance (S31).

In this section, we have analyzed why Turkey partially privatized hospital and health insurance markets in the context of its landmark health insurance reform. We have demonstrated that the introduction of private options was originally not envisioned by the reform team and indeed was notably absent from the Social Security and Universal Health Insurance Law legislated in 2006. Significant private options in healthcare delivery and financing were only introduced through the back door—when the law had to be amended in 2007/2008—and following substantial lobbying from the private hospital and insurance industries. Turkey's health ministry long resisted the full implementation of these private options, but only until the 2013 appointment as health minister of Mehmet Müezzinoğlu, the co-owner of several private hospitals. Turkey's introduction of private options in healthcare delivery and financing was therefore far from predetermined and only materialized as the result of a struggle between different economic interests and political ideas.

Policy Feedback Effects of Private Options

What are the political consequences of (partial) healthcare privatization? More specifically, how does the introduction of private healthcare options reconfigure the political dynamics of healthcare reform? Building on theories of policy feedback (Béland and Schlager 2019; Hacker 2002; Jacobs and Weaver 2015; Pierson 1993), this section traces the feedback effects of the introduction of private options as part of Turkey's 2008 health reform. While an analysis of socioeconomic consequences is beyond the scope of this article, existing research shows that partial privatization has made the Turkish healthcare system more segmented and unequal (Yilmaz 2013, 2021a). Focusing on political dynamics, the following analysis demonstrates that the creation of private options has propelled the growth of private hospital and health insurance markets as well as associated interest groups, which together has not only

led to a political entrenchment of this system of semi-privatized, segmented universal healthcare. At the same time, we show that accelerating feedback effects were limited by a strong and cost-conscious state.

Regulation of the Internal Market for Healthcare Provision

As detailed above, Turkey's 2008 health reform had established an internal market for healthcare provision that allowed all insurees of the public health insurance fund (SGK) to also visit private hospitals. This set up an institutional architecture, in which the SGK's reimbursement rules became critical market parameters and therefore natural lobbying targets for the private hospital industry.

This has motivated the hospital sector to organize and represent its collective interests more effectively. While Turkey's private hospital industry association, OHSAD, was established in 2004, right in the middle of the original health reform process, it has since consolidated its position as the main interest group that shapes and represents the demands of private healthcare providers (see Yilmaz 2017, 195). Since 2008, OHSAD's executive board has been chaired by Reşat Bahat, president and CEO of a midsized hospital chain. This is relevant to note, as the Turkish hospital sector has undergone a process of concentration since the 2000s, leading to the emergence of several hospital chains (see Vural 2017), such as Acibadem, Medical Park, and Medipol, which have at different times all been represented on OHSAD's executive board.

It should be noted that the development of Turkey's private hospital market cannot simply be periodized into pre- and post-2008 periods (see Fig. 1). Indeed, private hospital market expansion was most pronounced between 2005 and 2008, just before the passage of the 2008 health reform, "a laissez-faire period during which the state provided strong incentives for the expansion of private sector healthcare provision without making an effort to regulate the expansion" (Yilmaz 2017, 221). Only in 2008, shortly before health insurance reform, did the Turkish state begin to strictly regulate expansion, when the Ministry of Health introduced a pair of February 2008 regulations—which the industry later referred to as the "15 February Earthquake" (S32)—that required ministerial approval to build new or expand existing private hospitals (S33, S34). Since 2008, the Ministry of Health has been very hesitant in the granting of approvals for the building of new private hospitals, a situation that OHSAD has denounced as "unfair" (S35) and that has led large hospital groups to shift to a "growth through acquisition" strategy (Vural 2017, 279).

As a result of these regulations, the post-reform period has been characterized less by a massive expansion of the relative number of private hospitals, but rather by political struggles over the revenues and profits that private hospitals can make in a much more regulated market, dominated by a mandatory single-payer public insurance fund. The two central parameters in this regard have been the level of the SGK's reimbursement prices,[10] i.e., the reimbursement amounts that public and

[10] In Turkey, these reimbursement prices are known as "SUT prices" (*SUT fiyatları*), after the relevant ministerial regulation (*Sağlık Uygulama Tebliği*, SUT).

private hospitals receive from the state for the treatment of SGK insurees, and the level of additional payments that private healthcare providers are allowed to legally charge beyond these reimbursement prices.

In the following, we trace the political contestations between the hospital industry and the state over the post-reform adjustment of these parameters. We first discuss the conflict over additional payments, which dominated the agenda in the immediate aftermath of the reform, and then turn to the conflict over reimbursement prices, which has become more salient in recent years.

As we demonstrated above, Turkey's 2008 health reform had created the legal possibility for the state to decree the level of permissible additional fees (that private hospitals can charge SGK insurees) anywhere between 0 and 100%. This level had initially been set at 30%, relatively low within the possible range. This was largely due to the fact that Recep Akdağ, the AKP's first and longest-serving health minister (2002–2013 and 2016–2017) had been a pronounced skeptic of additional fees and the integration of for-profit private hospitals into the public healthcare system. Nevertheless, the state soon used the flexibility provided by the 2008 law and raised (by decree) the level of permissible additional fees from 30% to 70% in 2009 and to 90% in 2012. Active lobbying from the private hospital industry association, OHSAD, was a major reason behind this gradual expansion of private profit opportunities (I5).

Private hospitals remained unsatisfied with the permissible level of additional fees, preferring a complete deregulation of this parameter. An important political change occurred in January 2013, when the statist health minister Akdağ was succeeded by Mehmet Müezzinoğlu, a private hospital owner (S37). Soon after this change at the helm of the health ministry, in April 2013, the Turkish parliament passed a revision of the 2008 health insurance law, increasing the upper limit of permissible additional fees the state can set to 200%. In October 2013, the cabinet used these new legal flexibilities and increased the permissible level of additional fees from 90% to 200% (S38)—the level at which they remained in July 2022.

Lacking the ability to legally charge SGK patients more than the defined reimbursement prices plus the permissible additional fees, private hospitals developed a habit of illegally overcharging patients (Yilmaz 2017, 227–228, 2021b, 1383). Given a lack of effective sanctions, such as the termination of the SGK's cooperation agreements with culpable private hospitals (which had been envisioned in the 2006 draft bill but was also eliminated during the 2007–2008 revision process), it appears that the state has been turning a blind eye to this practice of overcharging. It is possible that the 2013 decision to raise the level of permissible additional fees to 200% was in part a response to this prevailing practice of illegal overcharging.

Since 2013, however, the Turkish government has been unwilling to further raise the level of additional payments, much to the frustration of the private hospital sector. Sector representatives have argued that additional fees of 200% are insufficient to cover the cost of some of the services and treatments offered at private hospitals (S39). A related source of private sector frustration has been the introduction of legal prohibitions on charging any additional fees for certain treatments, including emergency care and cancer care (S40, S41).

In the mid-2010s, policy debates surrounding the relationship of private hospitals with the public insurance system shifted from the issue of *additional fees* to the issue of *reimbursement prices*. The level of reimbursement prices has a dual significance for private hospitals, as it represents not only the size of public subsidies they receive, but also the base value of the additional fees they can charge SGK patients. For example, an increase of the reimbursement price for a particular treatment by, say, 100 TL, could increase a private hospital's (legal) revenues of for that treatment by 300 TL.

The private hospital sector had therefore long demanded an adjustment of reimbursement prices, eventually even arguing that non-adjustment could result in hospital closure (S42). Despite the hospital sector's political influence, reimbursement prices remained unchanged for more than a decade (2007–2020). The SGK's strict, almost stubborn stance on reimbursement prices, which matter for purchases from both private and public hospitals, reflects the Turkish healthcare system's post-financial crisis emphasis of cost control through price regulation rather than benefit cuts (Dorlach 2016). In 2013, health minister Müezzinoğlu told OHSAD members that reimbursement prices were not raised, because the Turkish state needed "to use the nation's money well" (S43).[11]

The political climate regarding an adjustment of reimbursement prices began to (slowly) change in the mid-2010s. The establishment of the Turkish Health Platform (*Türkiye Sağlık Platformu*, TÜSAP) in 2016, which brings together state actors (including bureaucrats from the various ministries and the presidency) with key business associations (including OHSAD and TSB) in five thematic conferences per year, provided an additional forum to communicate business interests and ideas. In 2017, the president of SGK acknowledged that the private hospital sector's survival depended on reimbursement prices, making their adjustment crucial (S45). A 2018 report by the government's recently established Turkish Institute for Health Policies recognized that the long non-adjustment of reimbursement prices created serious financial problems for private hospitals dependent on SGK insurees, acknowledging that "because SUT [reimbursement] prices are not determined according to their real costs, the state has to subsidize the deficits that occur at MoH [Ministry of Health] and university hospitals. However, private health organizations do not have such an opportunity" (S46).

The appointment of (the current) health minister Fahrettin Koca in April 2018 was another important turning point in this regard. Koca was founder and owner of Medipol, one of Turkey's largest private hospital chains, and was serving as OHSAD vice president at the time of his appointment. Shortly after Koca's appointment, OHSAD's president pointed out that his "very close friend" had become health minister and he was expecting "to solve a lot of things" under his leadership, after having previously highlighted that the hospital sector was "especially expecting an adjustment of SUT [reimbursement] prices" (S47, S48, S49). Indeed, at a

[11] This long-lasting impasse on reimbursement prices, which has limited private hospitals' profit opportunities in the domestic market, has arguably also accelerated the private sector's turn to medical tourism as an additional, less strictly regulated revenue source (S44, see Yilmaz and Aktas 2021).

health sector conference in 2019, Koca already signaled that he thought that reimbursement prices should be "kept up-to-date" by "connecting them to a certain coefficient" (S50).

Indeed, in March 2020, right before the first case of COVID-19 was detected in Turkey (Kemahlıoğlu and Yeğen 2021), and after more than a decade of non-adjustment, reimbursement prices were eventually increased by the government, although just slightly, by rates between 10% and 25% (S51). OHSAD issued a thank you statement detailing how they had long lobbied the SGK, the Ministry of Health, and the office of the president (S52). Under the impact of the COVID-19 pandemic and surging inflation, reimbursement prices were raised again in 2021 (by 10% to 20%) and 2022 (by 35% to 75%) (S53).

Implementation and Promotion of Supplementary Health Insurance

As demonstrated above, a last-minute amendment to Turkey's 2008 health reform had granted the Turkish Treasury the authority to introduce supplementary health insurance by decree. However, the Treasury initially did not make use of this option, primarily because Akdağ continued to resist the implementation of supplementary health insurance throughout his initial tenure as health minister (2002–2013) (I6). For the private health insurance industry, the 2008 health reform therefore only represented a partial victory, and it needed to continue to actively advocate for an implementation of supplementary health insurance in the post-reform period.

Turkey's private health insurance industry is organized in a specialized health insurance committee of the Insurance Association of Turkey (TSB). The TSB's advocacy goals explicitly include the promotion of supplementary health insurance (S54). However, supplementary health insurance was not implemented during Akdağ's time as health minister. Only after his replacement with Müezzinoğlu in 2013 did Turkey's Treasury eventually used its authority to implement supplementary health insurance (S55). TSB had communicated its demands about supplementary health insurance before the relevant SGK regulation was published in July 2012 (S56). The TSB's Health Insurances Review and Research Committee wrote to the Treasury and met with the general director of the SGK's Universal Health Insurance unit (S57). It is interesting to note that this 2012 meeting was also attended by OHSAD and that discussions about the introduction of supplementary health insurance were closely linked to discussions about the need for an adjustment of reimbursement prices. Given the low levels of reimbursement prices, health insurance providers feared that supplementary health insurance policies could face outsized financing demands from patients and private hospitals.[12] Yet, after the 2013 implementation of supplementary health insurance and the raise, in the same year, of the level of permissible additional payments from 90% to 200%, hopes were high that there could be substantial demand for supplementary health insurance (S59).

[12] Later, in 2018, TSB and OHSAD established a joint working group to "improve the collaboration of insurance firms and health service providers in private health insurance activities" (S58).

Table 2 Population coverage of health insurance schemes (%)

Insurance scheme	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Public (SGK)	80.7	83.5	85.8	83.2	81.9	83.7	85.5	85.5	87.1	85.6	85.0	87.0	87.5
Private supplementary	-	-	-	-	-	0.1	0.2	0.5	0.8	1.1	1.6	1.9	3.1
Private full	n/a	n/a	n/a	n/a	n/a	n/a	2.7	2.9	2.5	2.7	2.8	2.8	3.0

Sources: SGK (S68), TSB (S69)

Initial market growth, however, was weak, with the number of supplementary health insurance policies reaching 676,000 in 2017 (S60), corresponding to 0.8% of the Turkish population and 1.0% of all SGK insurees (see infra Table 2). Insurance sector representatives quickly began to argue that public support measures would be needed to boost the expansion of supplementary health insurance. Already in 2015, TSB had published a report evaluating different methods of supplementary health insurance promotion (S61, S62), which it presented to the Treasury. In particular, health insurance companies called for financial incentives to increase demand for supplementary health insurance (S63). TSB's secretary general specifically argued that state-subsidized financial incentives would be necessary to make supplementary health insurance attractive to lower-income population segments (S64). Another specific policy demand of TSB was a state-financed incentive for employers and employees to purchase group policies. Indeed, Turkey's eleventh development plan (2019–2023) called for benefits to be provided to the employers for group policies "in order to improve supplementary health insurance" (S65). Accordingly, it is now possible to get a 15% tax refund (up from previously 5%) on supplementary health insurance premiums. As a result, group policies today account for the majority of sold supplementary health insurance policies, with some employers switching from the more expensive full private health insurance to cheaper supplementary health insurance (S66). Indeed, group policies of supplementary health insurance have recently begun to become included in collective bargaining agreements (Erdoğan 2020, 17–18).

Despite eight years of time for growth and the introduction of some public support measures, the overall development of supplementary health insurance market continues to be meager (see Table 2). Growth has accelerated in the past two years, prompted by the insurance sector's decision to include COVID-19 treatments in the coverage of supplementary health insurance, reaching 2.6 million SGK insurees in 2021. Nevertheless, this number still only represents 3.1% of the Turkish population (and 3.5% of SGK insurees). Overall, then, the development of the supplementary health insurance market has been a disappointment for the insurance industry, as it had hoped to reach a larger share of SGK insurees with this new insurance product (S67).

Another goal of the private insurance industry was an adjustment of the SGK's basic benefit package, as more limited public health insurance benefits could drive demand for private supplementary health insurance. Indeed, according to leading insurance sector executives, enthusiasm for private insurance among the public was limited because the coverage of public health insurance has been perceived as comprehensive enough (Özsarı and Güdük 2020, 532). The policy idea has begun to be discussed by some state actors. For instance, in 2020, the head of Turkey's Presidency of Strategy and Budget stated at a conference organized by the hospital industry that "by narrowing the basic benefits package, more room for supplementary health insurance should be made" and that "incentives through tax support or state contribution" could be made (S70). However, the feared downward adjustment to the SGK's basic benefits package has not (yet) taken place. The limited demand for supplementary health insurance might have acted as a disincentive for the government to retrench the public benefits package. In addition, health reform has long been considered as one of the most popular policy reforms of the AKP's early years in government. As a result, the private option of supplementary health insurance introduced as part of Turkey's 2008 health reform continues to fall short of (business) expectations.

Conclusion

In this article, we have traced the partial privatization of healthcare financing and provision that was introduced as part of Turkey's 2008 health reform. While the reform has been central to expanding healthcare coverage in Turkey and has since become a global "success story" of achieving Universal Health Coverage (Agartan 2021), its privatization component has made Turkey's reformed healthcare system much more segmented and inequitable than originally envisioned. To explain this outcome politically, we have demonstrated that private options were included in Turkey's 2008 health reform only after persistent lobbying from organized business interests and after the replacement of statist with more market-friendly health policymakers. The resulting growth of private hospital and health insurance industries and the interest groups that represent them have led to the political entrenchment and, slow but steady, expansion of this system of private options. However, the influence of these new private healthcare providers should not be overstated, as they remain strictly regulated by a healthcare state with high monopsony power and limited political interest in rising private healthcare financing.

Our analysis makes several important contributions to the literature on the politics of Turkish health policy in the AKP era (see Agartan 2015; Harris 2019; Yilmaz 2017). First, we have uncovered the substantial changes between Turkey's original health reform bill of 2006 and the health reform law that was eventually passed in 2008, in particular with regard to private options. The Turkish healthcare system would thus look very different today if it had not been for the failure of the legislative process in 2006. Second, we have demonstrated that the eventual introduction of private options was driven by purposeful lobbying from the hospital and insurance industries—and not in any meaningful way by international organizations such as the World Bank. Third, we have shown that the AKP government has been internally split regarding the appropriate role of private actors in healthcare—between the influential statist Akdağ and a more market-friendly camp around figures such as Müezzinoğlu and Koca. Shifts in the balance of power between these two factions explain several key changes in Turkish health policy. Fourth, we have also documented that, despite the introduction of private options, Turkey's post-reform healthcare system is far from being a business paradise. Indeed, the Turkish state has used its monopsonistic power in the healthcare sector to strictly regulate prices and thus contain costs, and its continued commitment to a comprehensive public basic benefits package has stifled the growth of private health insurance. These new insights contribute to a better understanding of contemporary Turkish health politics.

These empirical insights translate into a series of theoretical contributions regarding healthcare privatization in the context of expansionary healthcare reforms. Regarding the initial introduction of private options, we have shown that the causal influence of international organizations, and the World Bank in particular, should not be overestimated, even if reform outcomes are congruent with their policy prescriptions (see de Carvalho and Frisina Doetter 2022). This skepticism about the World Bank's influence on healthcare reform outcomes is in line with recent case study findings from Costa Rica (Noy 2015, 2017), Croatia (Malinar 2022), and Ghana (Wireko and Beland 2017). Our findings regarding the timing and context of the introduction of private options in Turkey also support the "quiet politics" hypothesis that posits that business power will be higher when the political salience of a given policy issue is lower (see

Culpepper 2010). We also confirm the centrality of ideology for privatization reforms (see Appel 2000; Castiglioni 2001) but highlight the ideological convictions of individual policymakers rather than the broad ideology of the entire government.

Regarding post-reform dynamics, our analysis broadly corroborates the Skocpolian view "that policy reform outcomes are never really settled" (Patashnik 2003, 210) and contributes to the incipient literature on "neoliberal policy feedback" (Dargent Bocanegra 2022; also see Busemeyer and Iversen 2020; Ewig and Kay 2011). We show that the introduction of private options in healthcare—at least in the presence of sufficient public options—has very limited self-undermining feedback effects and that the emergence of a Polanyian double movement should therefore not be expected (see Wang 2010). Instead, we confirm theories that highlight the self-reinforcing—and even "accelerating" (Busemeyer et al. 2021)—feedback effects of privatization via the creation of new interest groups (Ewig and Kay 2011). We also show, however, that healthcare privatization does not necessarily lead to highly powerful and profitable producers. Indeed, if strictly regulated, it can also mean the construction of a state-driven "managed market" (Gingrich 2011, 12–13) in pursuit of efficiency enhancement and cost containment.

Our findings are highly relevant in the context of ongoing reform efforts toward universal health coverage and debates about the appropriate role of the private sector in these efforts (Harris and Libardi Maia 2021; Kumar 2019). One rather basic but immensely important point is that health reformers considering the introduction of private options should be extremely deliberate, as the introduction of private options is very difficult to reverse. The fact that private options can get "locked in" becomes especially salient given the doubtful outcomes of healthcare privatization in the Global South (Basu et al. 2012). The COVID-19 pandemic might well have increased political pressure to further expand healthcare coverage (see Dorlach 2023). But the recent global economic downturn has also created increased fiscal pressure on public healthcare systems. It therefore seems likely that in the foreseeable future privatization proposals will remain central to debates about achieving universal health coverage in the Global South.

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References

Adaman, Fikret, Oya Pinar Ardiç, Burçay Erus, and Didem Tüzemen. 2009. Hospital choice: Survey evidence from Istanbul. *Turkish Studies* 10 (3): 443–468.

Agartan, Tuba. 2012. Marketization and universalism: Crafting the right balance in the Turkish healthcare system. *Current Sociology* 60 (4): 456–471.

Agartan, Tuba. 2015. Explaining large-scale policy change in the Turkish health care system: Ideas, institutions, and political actors. *Journal of Health Politics, Policy and Law* 40 (5): 971–999.

Agartan, Tuba. 2021. Politics of success stories in the path towards universal health coverage: The case of Turkey. *Development Policy Review* 39 (2): 283–302.

Appel, Hilary. 2000. The ideological determinants of liberal economic reform: The case of privatization. *World Politics* 52 (4): 520–549.

Armada, Francisco, Carles Muntaner, and Vicente Navarro. 2001. Health and social security reforms in Latin America: The convergence of the World Health Organization, the World Bank, and transnational corporations. *International Journal of Health Services* 31 (4): 729–768.

Aspinall, Edward. 2014. Health care and democratization in Indonesia. *Democratization* 21 (5): 803–823.

Atun, Rifat, Sabahattin Aydın, Sarbani Chakraborty, Safir Sümer, Meltem Aran, Ipek Gürol, Serpil Nazlıoğlu, et al. 2013. Universal health coverage in Turkey: Enhancement of equity. *The Lancet* 382 (9886): 65–99.

Basu, Sanjay, Jason Andrews, Sandeep Kishore, Rajesh Panjabi, and David Stuckler. 2012. Comparative performance of private and public healthcare systems in low-and middle-income countries: A systematic review. *Plos Medicine* 9 (6): e1001244.

Béland, Daniel, and Edella Schlager. 2019. Varieties of policy feedback research: Looking backward, moving forward. *Policy Studies Journal* 47 (2): 184–205.

Béland, Daniel, Andrea Louise Campbell, and R. Kent Weaver. 2022. *Policy feedback: How policies shape politics*. Cambridge: Cambridge University Press.

Bernales-Baksai, Pamela. 2020. Tackling segmentation to advance universal health coverage: Analysis of policy architectures of health care in Chile and Uruguay. *International Journal for Equity in Health* 19 (1): 1–11.

Birn, Anne-Emanuelle, Laura Nervi, and Eduardo Siqueira. 2016. Neoliberalism redux: The global health policy agenda and the politics of cooptation in Latin America and beyond. *Development and Change* 47 (4): 734–759.

Bossert, Thomas, and Pablo Villalobos Dintrans. 2020. Health reform in the midst of a social and political crisis in Chile, 2019–2020. *Health Systems & Reform* 6 (1): e1789031.

Buğra, Ayşe. 2020. Politics of social policy in a late industrializing country: The case of Turkey. *Development and Change* 51 (2): 442–462.

Buğra, Ayşe, and Çağlar Keyder. 2006. The Turkish welfare regime in transformation. *Journal of European Social Policy* 16 (3): 211–228.

Busemeyer, Marius, and Torben Iversen. 2020. The welfare state with private alternatives: The transformation of popular support for social insurance. *The Journal of Politics* 82 (2): 671–686.

Busemeyer, Marius, Aurélien Abrassart, and Roula Nezi. 2021. Beyond positive and negative: New perspectives on feedback effects in public opinion on the welfare state. *British Journal of Political Science* 51 (1): 137–162.

Castiglioni, Rossana. 2001. The politics of retrenchment: The quandaries of social protection under military rule in Chile, 1973–1990. *Latin American Politics and Society* 43 (4): 37–66.

Cesur, Resul, Pinar Mine Güneş, Erdal Tekin, and Aydogan Ulker. 2017. The value of socialized medicine: The impact of universal primary healthcare provision on mortality rates in Turkey. *Journal of Public Economics* 150 (June): 75–93.

Culpepper, Pepper D. 2010. *Quiet politics and business power: Corporate control in Europe and Japan*. Cambridge: Cambridge University Press.

Dale, Gareth. 2012. Double movements and pendular forces: Polanyian perspectives on the neoliberal age. *Current Sociology* 60 (1): 3–27.

Dargent Bocanegra, Eduardo. 2022. The limits of neoliberal policy feedback: Private pension fund reforms in Peru (2014–2021). *Journal of Politics in Latin America* 14 (2): 190–210.

De Carvalho, Gabriela. 2022. The World Bank and healthcare reforms: A cross-national analysis of policy prescriptions in South America. *Social Inclusion* 10 (1): 5–18.

De Carvalho, Gabriela, and Lorraine Frisina Doetter. 2022. The Washington Consensus and the push for neoliberal social policies in Latin America: The impact of international organisations on Colombian healthcare reform. In *International Impacts on Social Policy*, ed. Frank Nullmeier, Delia González de Reufels, and Herbert Obinger, 211–224. Cham: Palgrave Macmillan.

Dorlach, Tim. 2015. The prospects of egalitarian capitalism in the global South: Turkish social neoliberalism in comparative perspective. *Economy and Society* 44 (4): 519–544. https://doi.org/10.1080/03085147.2015.1090736.

Dorlach, Tim. 2016. The AKP between populism and neoliberalism: Lessons from pharmaceutical policy. *New Perspectives on Turkey* 55 (November): 55–83. https://doi.org/10.1017/npt.2016.23.

Dorlach, Tim. 2021. Business interests, conservative economists, and the expansion of noncontributory pensions in Latin America. *Politics & Society* 49 (2): 269–300. https://doi.org/10.1177/0032329220952269.

Dorlach, Tim. 2023. Introduction: Exploring the long-term social policy consequences of COVID-19. *Global Social Policy* 23 (2): 343–347. https://doi.org/10.1177/14680181231180516.

Erdoğan, Cansu. 2020. Expanding supplementary voluntary private health insurance in Turkey: How and why?, Working paper Bielefeld University. https://perma.cc/XS3Z-DG28.

Erus, Burcay, Burcu Yakut-Çakar, Sanda Cali, and Fikret Adaman. 2015. Health policy for the poor: An exploration on the take-up of means-tested health benefits in Turkey. *Social Science and Medicine* 130: 99–106.

Esen, Berk, and Sebnem Gumuscu. 2016. Rising competitive authoritarianism in Turkey. *Third World Quarterly* 37 (9): 1581–1606.

Ewig, Christina, and Stephen J. Kay. 2011. Postretrenchment politics: Policy feedback in Chile's health and pension reforms. *Latin American Politics and Society* 53 (4): 67–99.

Filgueira, Fernando. 2013. Los regímenes de bienestar en el ocaso de la modernización conservadora: posibilidades y límites de la ciudadanía social en América Latina. *Revista Uruguaya de Ciencia Política* 22: 10–27.

Fillol, Amandine, Lara Gautier, and Valérie Ridde. 2021. L'avènement de la couverture sanitaire universelle dans la gouvernance globale. *Revue Internationale des Etudes du Developpement* 247 (3): 139–172.

Fullman, Nancy, M. Barber Ryan, Abajobir Amanuel Alemu, Abate Kalkidan Hassen, Abbafati Christiana, M. Abbas Kaja, Abd-Allah Foad, et al. 2017. Measuring progress and projecting attainment on the basis of past trends of the health-related Sustainable Development Goals in 188 countries: An analysis from the Global Burden of Disease Study 2016. *The Lancet* 390 (10100): 1423–1459.

Gingrich, Jane R. 2011. *Making markets in the welfare state: The politics of varying market reforms*. Cambridge: Cambridge University Press.

Greer, Scott L., and Claudio A. Méndez. 2015. Universal health coverage: A political struggle and governance challenge. *American Journal of Public Health* 105 (S5): S637–S639.

Grépin, Karen A., and Kim Yi Dionne. 2013. Democratization and universal health coverage: A case comparison of Ghana, Kenya, and Senegal. *Global Health Governance* 6 (2): 1–27.

Hacker, Jacob S. 2002. *The divided welfare state: The battle over public and private social benefits in the United States*. Cambridge: Cambridge University Press.

Hamzaoglu, Onur. 2020. Concealed infant deaths in Turkey and regional inequality. *International Journal of Health Services* 50 (2): 209–217.

Harris, Joseph. 2019. The politics of expanding healthcare access to the poor and informal sectors. *Sociological Forum* 34 (4): 818–837.

Harris, Joseph, and Juliana Libardi Maia. 2021. Universal healthcare does not look the same everywhere: Divergent experiences with the private sector in Brazil and Thailand. *Global Public Health* 17 (9): 1809–1826.

Hazama, Yasushi. 2015. Health reform and service satisfaction in the poor: Turkey 2003–11. *Turkish Studies* 16 (1): 36–53.

Holland, Alisha C. 2018. Diminished expectations: Redistributive preferences in truncated welfare states. *World Politics* 70 (4): 555–594.

Horton, Richard, and Selina Lo. 2013. Turkey's democratic transition to universal health coverage. *The Lancet* 382 (9886): 3.

Jacobs, Allan M., and R. Kent Weaver. 2015. When policies undo themselves: Self-undermining feedback as a source of policy change. *Governance* 28 (4): 441–457.

Kaasch, Alexandra. 2015. *Shaping global health policy: Global social policy actors and ideas about health care systems*. London: Palgrave Macmillan.

Kemahlıoğlu, Özge, and Oya Yeğen. 2021. Surviving the COVID-19 pandemic under right-wing populist rule: Turkey in the first phase. *South European Society and Politics*. https://doi.org/10.1080/13608746.2021.1985497.

Kesici, Zeynep, and Volkan Yilmaz. 2023. Insurance-based disparities in breast cancer treatment pathways in a universal healthcare system: A qualitative study. *BMC Health Services Research* 23 (1): 112.

Kumar, Ramya. 2019. Public–private partnerships for universal health coverage? The future of "free health" in Sri Lanka. *Globalization and Health* 15 (1): 1–10.

Kumar, Ramya, and Anne-Emanuelle Birn. 2018. Universal health coverage can best be achieved by public systems. *BMJ Opinion, August 24* https://perma.cc/C45P-RAJ5.

Lawn, Joy E., Jon Rohde, Susan Rifkin, Miriam Were, Vinod K. Paul, and Mickey Chopra. 2008. Alma-Ata 30 years on: Revolutionary, relevant, and time to revitalise. *The Lancet* 372 (9642): 917–927.

Malinar, Ante. 2022. The role of the World Bank and the International Monetary Fund in the healthcare financing reforms in Croatia: Transfer of ideas and limited coercion. *Global Social Policy* 22 (3): 540–559.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2016. *The quest for universal social policy in the South: Actors, ideas and architectures*. Cambridge: Cambridge University Press.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2018. Undoing segmentation? Latin American health care policy during the economic boom. *Social Policy & Administration* 52 (6): 1181–1200.

McCoy, David, and Linsey McGoey. 2011. Global health and the gates foundation—in perspective. In *Partnerships and foundations in global health governance*, ed. Simon Rushton and Owain D. Williams, 143–163. London: Palgrave Macmillan.

Moravcsik, Andrew. 2014. Transparency: The revolution in qualitative research. *PS Political Science & Politic* 47 (1): 48–53.

Noy, Shiri. 2015. The Washington consensus and social policy: World Bank projects and health sector reform in Costa Rica. *Latin American Policy* 6 (2): 182–204.

Noy, Shiri. 2017. *Banking on health: The World Bank and health sector reform in Latin America*. Cham: Palgrave Macmillan.

Noy, Shiri. 2018. Healthy targets? World Bank projects and targeted health programmes and policies in Costa Rica, Argentina, and Peru, 1980–2005. *Oxford Development Studies* 46 (2): 164–183.

Ökem, Zeynep Güldem, and Mehmet Çakar. 2015. What have health care reforms achieved in Turkey? An appraisal of the "Health Transformation Programme". *Health Policy* 119 (9): 1153–1163.

Öniş, Ziya. 2012. The triumph of conservative globalism: The political economy of the AKP era. *Turkish Studies* 13 (2): 135–152.

Özsarı, Haluk, and Özden Güdük. 2020. Bazı sigorta şirketi yöneticilerinin Türkiye'de özel sağlık sigortacılığı üzerine bir değerlendirmesi. *Acıbadem Üniversitesi Sağlık Bilimleri Dergisi* 11 (3): 526–536.

Pala, Kayihan, Özgür Erbaş, Eriş Bilaloğlu, Bayazit İlhan, Mehmet Raşit Tükel, and Sinan Adıyaman. 2018. Public private partnership in health care: Case of Turkey. *World Medical Journal* 64 (4): 44–48.

Park, Susan, and Antje Vetterlein, eds. 2010. *Owning development: Creating policy norms in the IMF and the World Bank*. Cambridge: Cambridge University Press.

Patashnik, Eric. 2003. After the public interest prevails: The political sustainability of policy reform. *Governance* 16 (2): 203–234.

Pierson, Paul. 1993. When effect becomes cause: Policy feedback and political change. *World Politics* 45 (4): 595–628.

Sadock, Musa, and Alex Veit. 2021. International trailblazer: Primary health care in Tanzania, 1920s-1990s. *SOCIUM SFB 1342 WorkingPapers*, 19. https://perma.cc/4UG9-Z8PM.

Sparkes, Susan Powers, Jesse B. Bump, and Michael R. Reich. 2015. Political strategies for health reform in Turkey: Extending veto point theory. *Health Systems & Reform* 1 (4): 263–275.

Sparkes, Susan Powers, Rifat Atun, and Till Bärnighausen. 2019a. The impact of the family medicine model on patient satisfaction in Turkey: Panel analysis with province fixed effects. *PLOS One* 14 (1): e0210563.

Sparkes, Susan Power, Jesse B. Bump, Ece A. Özçelik, Joseph Kutzin, and Michael R. Reich. 2019b. Political economy analysis for health financing reform. *Health Systems & Reform* 5 (3): 183–194.

Tichenor, Marlee, and Devi Sridhar. 2017. Universal health coverage, health systems strengthening, and the World Bank. *BMJ* 358: j3347.

Trampusch, Christine, and Bruno Palier. 2016. Between X and Y: How process tracing contributes to opening the black box of causality. *New Political Economy* 21 (5): 437–454.
Trein, Philipp. 2017. Coevolution of policy sectors: A comparative analysis of healthcare and public health. *Public Administration* 95 (3): 744–758.
Vargas Bustamante, Arturo, and Claudio A. Méndez. 2014. Health care privatization in Latin America: Comparing divergent privatization approaches in Chile, Colombia, and Mexico. *Journal of Health Politics, Policy and Law* 39 (4): 841–886.
Vural, Ipek Eren. 2017. Financialisation in health care: An analysis of private equity fund investments in Turkey. *Social Science & Medicine* 187: 276–286.
Wang, Shaoguang. 2010. China's double movement in health care. *Socialist Register* 46: 240–261.
Weyland, Kurt. 2006. *Bounded rationality and policy diffusion*. Princeton: Princeton University Press.
Wireko, Ishmael, and Daniel Béland. 2017. Transnational actors and health care reform: Why international organizations initially opposed, and later supported, social health insurance in Ghana. *International Journal of Social Welfare* 26 (4): 405–415.
Wireko, Ishmael, Daniel Béland, and Michael Kpessa-Whyte. 2020. Self-undermining policy feedback and the creation of National Health Insurance in Ghana. *Health Policy and Planning* 35 (9): 1150–1158.
Yeğen, Oya. 2018. Judicial "empowerment" through constitutional change: The case of Chilean and Turkish constitutional courts. *Research and Policy on Turkey* 3 (1): 40–67. https://doi.org/10.1080/23760818.2018.1445233.
Yeşil, Bilge. 2018. Authoritarian turn or continuity? Governance of media through capture and discipline in the AKP era. *South European Society and Politics* 23 (2): 239–257.
Yilmaz, Volkan. 2013. Changing origins of inequalities in access to health care services in Turkey: From occupational status to income. *New Perspectives on Turkey* 48 (March): 55–77.
Yilmaz, Volkan. 2017. *The politics of healthcare reform in Turkey*. Cham: Palgrave Macmillan.
Yilmaz, Volkan. 2021a. Exploring patient experiences of the internal market for healthcare provision in Turkey: Publicness under pressure. *Journal of Social Policy* 50 (3): 588–605.
Yilmaz, Volkan. 2021b. Rethinking universal health coverage: A qualitative study of patient organisation perspectives on the Turkish health-care system. *Sociology of Health & Illness* 43 (6): 1372–1387.
Yilmaz, Volkan, and Puren Aktas. 2021. The making of a global medical tourism destination: From state-supported privatisation to state entrepreneurialism in healthcare in Turkey. *Global Social Policy* 21 (2): 301–318.
Yilmaz, Volkan. 2021c. The contemporary politics of health in Turkey: Diverse actors, competing frames, and uneven policies. In *The Oxford Handbook of Turkish Politics*, ed. Günes Murat Tezcür, 249–272. Oxford: Oxford University Press.
Yip, Winnie, and William C. Hsiao. 2015. What drove the cycles of Chinese health system reforms? *Health Systems & Reform* 1 (1): 52–61.
Yörük, Erdem. 2022. *The politics of the welfare state in Turkey: How social movements and elite competition created a welfare state*. Ann Arbor: University of Michigan Press.

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