CHARLES UNIVERSITY IN PRAGUE
FACULTY OF SOCIAL SCIENCES
INTERNATIONAL ECONOMIC
AND POLITICAL STUDIES

MASTER'S THESIS

HEALTH CARE FINANCING AND ECONOMIC DEVELOPMENT: A COMPARATIVE STUDY OF THE CZECH REPUBLIC AND TURKEY

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Academic Year:	**2012/2013**
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Date Submitted:	**17 May 2013**

ABSTRACT

Health care systems in many countries around the world have been subject to major reform initiatives since 1980s and 1990s. The main rationale for reform was an increasing need to control costs in health care as the countries struggled to adapt to the global economic conjuncture and deal with their financial problems. The movement to reform health care arose in that context and spread amongst health care experts and policy makers. The aim of this study is to understand how reforms were initiated and what forces drove them. This topic is addressed through the case studies of change in health care policies in Turkey and the Czech Republic, both of which having experienced the influence of global economic trends, yet are defined by fundamentally different economic, political and social conditions. The findings of the study support that health policy ideas were diffused to the two countries via international policy networks; domestic contexts facilitated the diffusion. Interest groups were important actors in both countries, but the role played by various groups differed in the two countries. Finally, the countries appear to have tendency to converge to a certain degree with regard to their health financing system.

Key words: Health care reform, policy diffusion, globalization, Czech Republic, Turkey.

Declaration of Authorship

1. The author hereby declares that she compiled this thesis independently, using only the listed resources and literature.

2. The author hereby declares that all the sources and literature used have been properly cited.

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Prague, May 17th, 2013

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DECLARATION:

I hereby declare that this thesis is my own work, based on the sources and literature listed in the appended bibliography. The thesis as submitted is 125.230 keystrokes long (including spaces), i.e. 62 manuscript pages.

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Ayşe Jakubcová

Acknowledgements

Writing this thesis has been a very challenging, yet enriching process.

My gratitude goes primarily to MUDr. Petr Háva, my supervisor, for his continuous support of my work and his willingness to share his thoughts with me on numerous occasions. His enthusiasm and expertise about health policy drew me into this field.

I am also more than grateful to Prof. Vladimír Benáček, whose guidance and encouragement helped me in the most important phase of my thesis.

My special thanks go to my dear friend Hugo Duivenvoorden for his invaluable assistance.

My parents and brother have always been a source of inspiration for their dedication and passion towards academic work. I have always felt their support and I am grateful for their presence in my life.

Master Thesis Proposal

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Proposed Topic:

Health care financing and economic development: A comparative study of the Czech Republic and Turkey

Registered in SIS: Yes Date of registration: 03.03.2011

Remark: the registration requires the approval by Dr. Riegl and (in the final stage) a signature of the supervisor.

Topic Characteristics:

Health care systems in many countries around the world have been subject to major reform initiatives since 1980s and 1990s. The main rationale for reform was an increasing need to control costs in health care as the countries struggled to adapt to the global economic conjuncture and deal with their financial problems – limiting public spending was seen as a way of achieving cost control. The movement to reform health care arose in that context and spread amongst health care experts and policy makers.

The aim of my study is to understand how reforms were initiated and what forces drove them. The main question here is the following: "Why would countries with different levels of economic development and health care systems bring forth reforms which have common dimensions in the last few decades?" In relation to that, "Do such reforms cause a convergence among the health care systems with similar implications for their welfare states or are the commonalities only at the surface at the level of reform proposals?" I will try to answer these questions through the case studies of change in health care policies in Turkey and the Czech Republic, both of which having experienced the influence of global economic trends, yet are defined by fundamentally different economic, political and social conditions. The materials I will use in this study include the government and political parties' programs, health sector expertise reports, documents of the Ministry of Health, and reports and data from OECD, World Bank and WHO.

Hypotheses:

1. The initiation of health care reforms in Turkey and the Czech Republic was driven by global forces, mainly by international organizations. I.e. institutionally driven reforms exogenous to the internal situation in the country.
2. Major variations in domestic context and structures led to divergence in the content and implementation of reforms. Problem-oriented reforms driven by domestic internal requirements implying that problems in all countries are similar.
3. Health care policies in the Czech Republic and Turkey become more and more similar over time.
4. Local lobbies (chamber of healthcare, big hospitals and producers of pharmaceuticals) "internalized" the strategy of reforms in both countries.

Methodology:

The theoretical framework employed in this study is based on the policy diffusion theory, which aims at

explaining the reason how and why a certain policy, which is implemented in one country is also adopted by other countries. The origin of the policy diffusion theory lies in the book *Diffusion of Innovations* of Everett Rogers (first published in 1962). Political scientists have applied Rogers' theory to policy analysis, focusing on the government element of the social system as the primary unit of analysis. In that sense, policy diffusion can be defined as a process where policy choices are interdependent at an international context. I will apply the comparative method to perform the case studies of the Czech Republic and Turkey and will adopt a qualitative approach, which allows for an in-depth study in this type of two-country comparison. For a systematical comparison, I will use the health policy analysis model proposed by Walt and Gilson (1994), given that health policies are formed through the complex relationship of context, actors and process. By doing this, this study will contribute to the existing understandings of policy diffusion and will offer an instrument for comparative studies to analyze policy changes in different countries.

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1. Introduction

"We want to see better health and well-being for all, as an equal human right. Money does not buy better health. Good policies that promote equity have a better chance."
Dr. Margaret Chan,
Director General of WHO

The last decades have witnessed a new era of common trends around the globe: Globalization and liberalization have been transforming many countries' economies since 1980s. The willingness of governments to open up their domestic economies to market forces including privatization of public services has been growing and the free movement of goods and capital impacted people's quality of life around the world (Simmons and Elkins, 2004). Market elements were also introduced into the field of health care with a widespread international movement to reform and the focus was on the *efficiency,* rather than the *equity* of health care systems in question (Twaddle, 2002, p.3).

With the 2000s, the balance between economic and social policies started to swing back, as social issues gained weight on the political agendas. The Lisbon Strategy of the European Union (2000), which was developed to address the economic and social challenges faced in the aftermath of the neoliberal era, pointed to such a change in policy priorities. However, income inequalities continued to increase in a large majority of the OECD countries since mid-1980s (OECD, 2011a). Europe 2020, which adopted a strengthened vision of "social market economy", was launched in 2010 as the updated EU strategy (Europe 2020). At the same time, the discourse on health as a human right, which has been enshrined in international treaties (such as United Nations' International Covenant on Economic, Social and Cultural Rights or the European Social Charter) since 1960s, has gained increasing prominence. In particular, the World Health Organization has been taking recently a more active role in promoting a human rights-based approach to health (WHO).

This study examines the change in health care policies in Turkey and the Czech Republic, two countries sharing the same ambition of accessing one of the largest global economies (European Union) and both experiencing the influence of global economic trends. As member states of WHO, they both agreed on the Health 2020 policy framework and share the goals of "significantly improving the health and well-being of populations, reducing health inequalities, strengthen public health and ensuring people-centered health systems that are universal, equitable, sustainable and of high quality" (WHO, 2012). At the same time, Turkey and the Czech Republic are defined by fundamentally different economic, political and social

conditions.

Turkey has been one of the countries where health reforms have been on the agenda since 1980. The Czech Republic, together with other Central and Eastern European countries, also opened to - and was included in - the process of liberalization and market integration, following the collapse of Communism.

Turkey was founded in 1923 as a republic and became a multi-party democracy in 1945. It has been a member of many Western organizations such as the Council of Europe, NATO and OECD since its foundation, and began full membership negotiations with the EU in 2005, although accession to the EU was on Turkish political agenda for several decades. The country realized a series of reforms in preparation for the EU membership, particularly in harmonizing its legal system with EU norms. In the Czech Republic, the process of democratization began in 1989, leading to democratic elections in 1990. Following the separation of the Czech and Slovak Republics in 1992, the Czech Republic was established as a multi-party parliamentary democracy. It has been a member of the OECD since 1995, and a member of the EU since 2004.

In Turkey, major indicators of health status such as infant mortality and life expectancy rates have improved considerably, mainly after the 1980s. In the last four decades, life expectancy in Turkey has improved from 54.2 to 74.3 years old on average; it has increased sharply, rapidly catching up with the OECD average (79.8 in 2010). In the Czech Republic, the life expectancy is 77.7 years on average, which is closer to EU and OECD averages (OECD, 2012).

While the Czech health care system went through major changes during the early 1990s, the process of reform has then slowed down. In the twenty-first century, the major reform debates have been around such topics as patients' direct payments to health care providers and more privatization. Reform of the health care system in Turkey came to the agenda during the liberalization of the economy in 1980s. The main reform issues were establishment of a universal insurance scheme, decentralization of state hospitals and allowing them to employ their own personnel (Savaş et al., 2002). In 2003, following the election of a single-party government, the health system entered in a process of structural change with the implementation of the *Health Transformation Program*.

The aim of my study is to understand how reforms were initiated and what forces drove them. Both countries are now faced with the challenge to balance economic growth and social progress. Influenced by global developments, the neoliberal wave and economic globalization, yet challenged by income and health inequalities, both Turkey and the Czech

Republic have been through a number of health care policy changes over the last three decades.

The main question here is the following: “Why would countries with different levels of economic development and different health care systems bring forth reforms which have common dimensions in the last few decades and have these reforms provided support for the achievement of Health 2020 goals?” The primary objective of this thesis is to address this question. Furthermore, it contributes to the existing understandings of policy diffusion. Finally, this thesis offers an instrument for comparative studies to analyze policy changes in different countries.

2. Research Design

In this chapter I will provide an overview of the theoretical framework underlying this study and will present the methodological approach and hypotheses.

2.1 Theoretical Framework

The theoretical framework employed in this study is based on the policy diffusion theory, which aims at explaining the reason how and why a certain policy that is implemented in one country is also adopted by other countries. It is a contemporary theory included in Paul Sabatier's *Theories of Policy Process* as one of the conceptually developed theories seeking "to explain much of the policy process" and addressing "conflicting values and interests, information flows, institutional arrangements, and variation in socioeconomic environment" (Sabatier, 2007, p.8).

The origin of the policy diffusion theory lays in the book *Diffusion of Innovations* of Everett Rogers, first published in 1962. A professor of rural sociology, Rogers defines the innovation diffusion as "the process by which an innovation is communicated through certain channels over time among the members of a social system" (Rogers, 1995, p. 5). Following from this definition, he proposes the four main elements of diffusion: The first element is *innovation*, which is "an idea, practice or object that is perceived as new by an individual or other unit of adoption" (Rogers, 1995, p. 11). *Communication channel*, the second element, is the means by which messages get from one individual to another and according to Rogers, "diffusion is a very social process" in that the imitation and modelling by potential adopters of their network partners who have adopted an innovation previously is central in the diffusion process (Rogers, 1995, p.18). The third element is *time*, which is involved in the decision process and in measuring the number of members of the system adopting the innovation in a given period of time (rate of adoption) (Rogers, 1995, p.18). The fourth element is *social system*, in which the diffusion occurs and its structure can facilitate or impede the diffusion of innovations in the system (Rogers, 1995, p.24-25).

Political scientists have applied Rogers' theory to policy analysis, focusing on the government element of the social system as the primary unit of analysis. Early policy diffusion studies have almost exclusively been utilized in the United States (Sabatier, 2007, p. 10). For example, Berry and Berry, in their studies dealing with states' adoption of state lotteries, examined the transfer of policies among local governments (Berry and Berry, 1990). They inquired the reason why policies spread and referred to two types of explanation in the

literature: internal determinants, which posit that the internal characteristics of a state, such as economic, political or social lead governments to innovate and regional diffusion model, which relates policy adoption to geographical proximity, assuming states are influenced from their neighbors in policy-making (Berry and Berry, 1990, pp. 395-396). In a different study published in 1992, Berry and Berry examined states' tax adoptions and found that an economic crisis increased the probability of tax adoption, since *a crisis situation could reduce the political risks of innovating* (Berry and Berry, 1992, p.718). Here, innovation is defined as a policy that is new to the state adopting it: A policy that already exists and is not new elsewhere is still considered new for the state, which adopts it (Berry and Berry, 1990).

The policy diffusion theory has come to be applied to international studies over time and scholars further elaborated on possible explanations of policy diffusions. For example, Dobbin et al. (2007) distinguished four mechanisms theorized to explain the diffusion of policies across the countries. The first mechanism they discussed is social constructivist explanation of diffusion. It can be defined as a "process whereby policies diffuse because of their normative and socially constructed characteristics". In social constructivist approach, the world is depicted with an increasingly global political culture which comprises a broad consensus on what should be the social actors, societal goals and means for achieving them (e.g. individuals, organizations, nation-states instead of clans and city-states, economic growth and social justice instead of territorial conquest, and so on). What is appropriate and legitimate is socially constructed and vary from one period to another (Dobbin et al., 2007, p. 451). Early constructivist studies tracing the diffusion of educational and human rights policies from the "First World" to the "Third World" found that "most countries changed policies not when they were developmentally ready but when they were influenced by global norms" (Dobbin et al., 2007, p. 451, Meyer et al., 1977). Meyer documented that in the first two decades following the World War II, diffusion of mass schooling happened in all sorts of countries, regardless of local characteristics, economic needs or infrastructure to support it. Education was basically "constructed as integral to modernity". A similar situation happened in the field of human rights: Countries signed human rights treaties committing to global norms, even when they were accused for rights abuses (Dobbin et al., 2007, p. 451).

In constructivist approach, understanding how policies become socially accepted is key in understanding why they diffuse - such an acceptance of a policy approach can happen through following the examples set by leading countries, experts groups advising policy-makers a new policy, or specialists making arguments about a policy's appropriateness. Policy-makers can imitate the policies of the country that seems to be doing best without fully understanding the

reasons for that success (Dobbin et al., 2007, p. 452). For example, Meseguer (2004) found that countries in Europe and Latin America imitated the strategies of role models in implementing privatization in their own countries. Expert communities also mattered in transferring policies; for example, it was found that "the number of American-trained economists in a country had a significant effect on the likelihood of a privatization event" (Dobbin et al., 2007, p. 452). In this sense, constructivists defend that even though the United States and international financial institutions such as the IMF and World Bank may promote policy models, the diffusion of those is not essentially through coercion, instead, the followers are willing to adopt these models (Dobbin et al., 2007, p. 452).

Levi-Faur's study (2005) on the diffusion of regulatory capitalism is a typical example of constructivist approach. For Levi-Faur, it is not surprising that when the domestic order in highly developed countries is changing, this order is also exported to other countries, since from a diffusion perspective "the regulatory order that was shaped in some leading countries and sectors is then diffused to the rest of the world" and this change is transferred through "the peculiar prisms of experts and actors of knowledge" (Levi-Faur, 2005, p. 24). A social interdependency exists between countries and actors who are linked by information, competition, cooperation and harmonization. Diffusion can happen not only among different countries, but also in the same country among different sectors (Levi-Faur, 2005).

A second mechanism explained by diffusion theorists is *coercion*. Coercion is an external determinant of diffusion involving a change in incentives to nations, meaning countries may adopt certain policies as a result of the pressure from powerful countries or international organizations. Conditionality used by IMF and World Bank tying financial help to neoliberal economic reforms or by the EU in making candidate countries accession conditional is a typical example of coercion (Gilardi, 2013, p. 459). Although conditionality is an identifiable element in the process of policy adoptions, researchers questioned the validity of conditionality explanation in policy diffusions and argued that governments accept IMF loans because they want conditions imposed on them (Vreeland, 2003) or that in the face of political opposition governments may prefer the policies to be imposed by outsiders (Drazen, 2002). For instance, Weyland (2005) in his study dealing with Latin American pension reform notes the following:

> *...the initial leader of Bolivia's pension reform effort reported that she asked World Bank officials on several occasions: "Póngame esta condición, por favor," that is, "Could you please impose this condition on us?" And the key adviser to Peru's economy minister mentioned that his team had asked the IFIs to impose conditions that they could then use to coax President Alberto Fujimori (1990–2000) into supporting their reform goals." (Weyland, 2005, p. 273).*

The third mechanism is *competition* between countries for capital and export markets to attract economic resources. An example of this is tax competition: A simplification of regulatory requirements or decrease of taxes by one country puts their competitors under pressure to follow the suit (Dobbin et al., 2007, p. 457). Another example is capital account liberalization that is implemented by developing countries' governments following one after the other and used as a signal to investors (Simmons and Elkins, 2004).

The fourth mechanism is *learning,* in the sense that policy-makers make use of the experience of other countries that implemented the policy in consideration. Two types of learning are distinguished: Bayesian updating and bounded rationality. Bayesian updating is a process in which "people add new data to prior knowledge and beliefs to revise their assessment of that knowledge" (Dobbin et al., 2007, p. 460). While this suggests a rational learning, it has been also argued that policy-makers may use cognitive shortcuts and focus on the most successful stories rather than collecting and systematically assessing all available information (Weyland, 2005, p. 281). Weyland, in his account of pension reform in Latin American countries, used a cognitive heuristics approach to learning, positing that "human rationality is inherently bounded by innate, insuperable limitations on information processing and memory capacity." Since people cannot meet the standards of rational choice, they resort to inferential shortcuts to arrive at decisions much easier. The three principal shortcuts are availability (people tend to place excessive importance on information that is available and grabs their attention), representativeness (people generalize from a narrow set of observations and treat the observed patterns as representatives of the whole population, and anchoring heuristics (an initial knowledge strongly affects people's subsequent judgments) (Weyland, 2005, p. 283-285). Applying this cognitive heuristics framework in gaining insight into the diffusion of social security reforms across Latin American countries, Weyland finds that cognitive heuristics are particularly useful in capturing regional concentration and neighborhood effects of pension privatization in Latin America through the example of Chile (availability), their distorted assessments of innovation's performance (representativeness) and their adaptation of Chilean model restricted to its original design and not adapted to local characteristics (anchoring) (Weyland, 2005, p. 295).

Within this framework of policy diffusion, the present study poses the following

questions: What are the similarities and differences in the health policy development between Turkey and the Czech Republic over the last decades? Was the health policy formation in these countries impacted from a global diffusion of policies? The answers to these questions will be covered in the next chapters.

2.2 Methodology

A considerable number of policy diffusion studies adopted quantitative methodologies. This type of analyses focuses on a large number of countries, states or institutions, which makes the comparison particularly suited to quantitative analysis of aggregate data. For example, Berry and Berry (1992) introduced a cross-sectional time series approach to policy innovation research relying on event history analysis, which has the objective to explain a qualitative change in individual's behavior - the change in behavior to be explained being policy adoption. The event history analysis method was also adopted by Jordana and Levi-Faur (2004) in their diffusion of regulatory agencies research; however, at the same time they used a qualitative and comparative historical approach to examine temporal, sectoral, and national variations in the process of sectoral change in Latin America. Another example of qualitative method used in policy diffusion studies is "process tracing", which involves looking at causal processes within a single case. For instance, Weyland (2005) applied process tracing within the cognitive heuristics framework to show the important role of pension privatization in Chile for reforms in other Latin American countries.

This study draws on the case studies of Turkey and the Czech Republic from a historical perspective with the purpose of understanding the similarities and differences between the two countries in terms of their health policy development. It applies the comparative method and adopts a qualitative approach, which allows for an in-depth study in this type of two-country comparison. The study mainly relies on documentary analysis and the sources used include the government and political parties' programs, health sector expertise reports, documents of the Ministry of Health, OECD, World Bank and WHO reports. It also uses quantitative data from OECD and WHO databases.

For a systematical comparison of the two countries, I will apply the health policy analysis model (Figure 1) as proposed by Walt and Gilson (1994), given that health policies are formed through the complex relationship of context, actors and process.

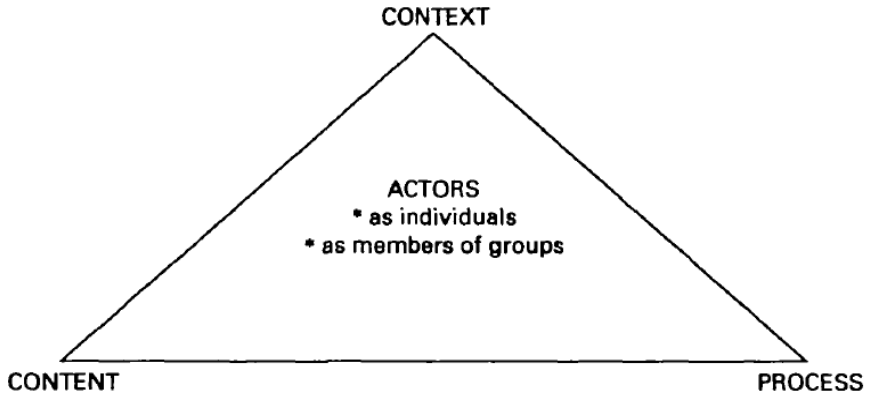

Figure 1: Walt and Gilson's model for health policy analysis (1994).

In this triangle, **actors** refer to interest groups, political parties, international organizations, private companies or individuals whose actions affect health policy. **Context** includes political, economic, social, cultural, domestic or international factors influencing health policy. **Content** refers to the particular policies, objectives and implementation plans and **process** is the way policies are initiated, developed or formulated, negotiated, communicated and implemented. Process includes different stages of policy development and involves dealing with actors.

Policy formation happens in the process corner of the triangle and is influenced by actors, content and context (Walt and Gilson, 1994). For the purposes of this study, this analytical framework is adapted to the policy diffusion perspective - with the suggestion that policy diffusion would merge in this framework via the process section leading to an outcome of policy adoption rather than policy formation. The first part of the case study will focus on understanding the mechanism of policy diffusion in each country.

The second part of the case study will describe the changes that occurred in the financing function of the health care systems.

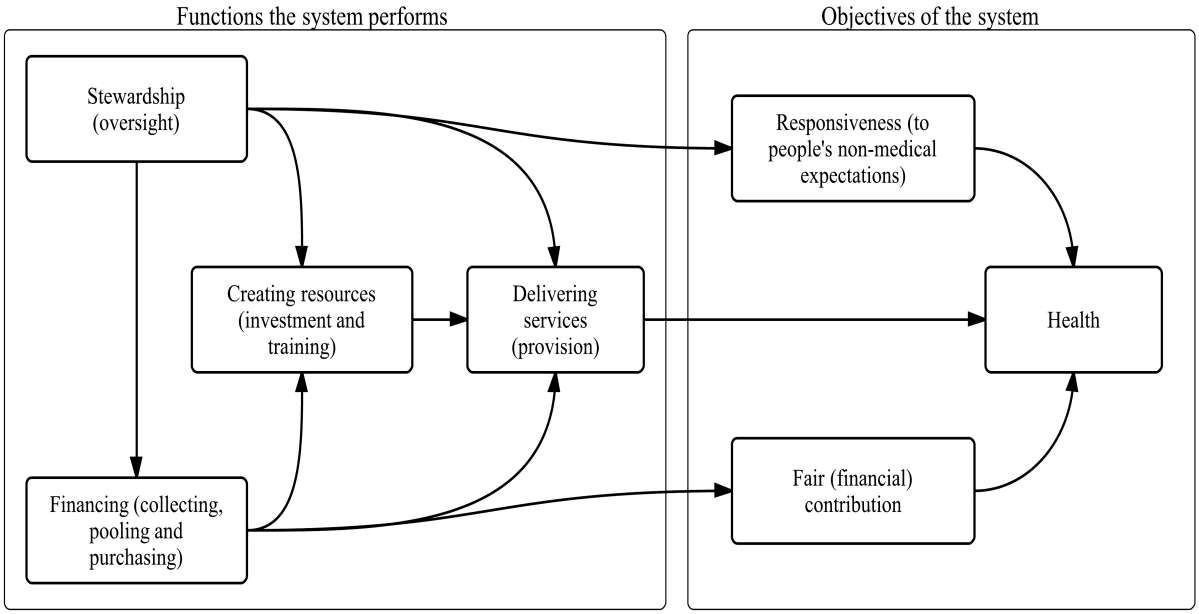

Figure 2: Functions and objectives of health systems (WHO, 2013).

As can be seen in Figure 2, the functions the health care system performs are related to the objectives of the system. In the WHO framework, these objectives are defined as:

- improving the health of the population served,
- responding to people's non-medical expectations, and
- providing financial protection against the costs of ill health.

Derived from these objectives are the financing objectives, which are essentially promotion of universal protection against financial risk and promotion of a more equitable distribution of the burden of funding the system. These will guide the comparison and evaluation of the changes in the Turkish and Czech health financing systems.

The hypotheses that will be tested in this study are the following:

1. The initiation of health care reforms in Turkey and the Czech Republic was driven by global forces, mainly by international organizations.
2. Major variations in domestic context and structures led to divergence in the implementation of reforms.
3. Health care policies in the Czech Republic and Turkey become more and more similar over time.
4. Local lobbies (medical associations, hospitals, pharmaceutical companies) "internalized" the strategy of reforms in both countries.

3. Turkey: Health policy development (since 1980s)

The global economic instability and recessions caused by oil crises in the early 1970s resulting in a declining resource base for governments, led to the development of neoliberal policies, which focused on the reduction of the state's role as a provider. The "new public management" trend, which brought a more market-oriented approach to the provision of public sector, has been influencing public sector reforms across both industrialized and non-industrialized countries since 1970s (Tritter et al., 2010; Steger, 2010). These policies covered the health care sector as well, and a wave of health sector reforms was spread around the world in the 1980s and 1990s. Many countries implemented reforms which had such common elements as decentralization in the organization of health care system, promotion of competition in the provision of health care services, strengthening the link between performance and reward, and financing of health care from non-tax revenue sources such as social health insurance and private health insurance (Mills, Bennett and Russel, 2001, p. 3-4). While cost containment reasons dominated the discourse in demanding for market reforms, the contribution the health care economy could make to economic competitiveness was also at stake (Moran, 1998).

How these reforms spread is a particular matter of interest. A number of studies highlighted the role of the international organizations such as the World Bank, IMF, OECD and EU in creating and promoting more market-oriented structures and regulatory reforms in health care (Price, Pollock and Shaoul, 1999; Tritter et al., 2010; Mills et al., 2001). In that context, some researchers explained the diffusion of new policies by focusing on the conditionality set by the international organizations (e.g. the IMF or the EU), i.e. requiring countries to accept certain policy prescriptions in return for financial aid, loans or other considerations, as a driving force for reform (Schimmelfennig and Sedelmeier, 2003; Brune, Garrett and Kogut, 2004). On the other hand, some studies questioned the role of conditionality by arguing that governments negotiating with international organizations wanted conditions to be imposed on them in order to deal with the opposition at the domestic level (Vreeland, 2003; Drazen, 2002; Weyland, 2005).

Some other studies focusing on the role of international organizations or agencies in the diffusion of market reforms explained the diffusion via receiving knowledge from international policy networks. These networks include the officials of international organizations, the domestic officials and the United States as a significant political power

influencing policies and practices of multilateral lending institutions. In this explanatory framework, the professionals working in international organizations are participants of "epistemic communities" who provide technical advice to the countries (Haas, 1992). These individuals convey a common model, which in this case is "greater reliance on the market" (Teichman, 2004, p.40).

The countries that are engaged with such international organizations are the recipients not only of financial support but also of ideas. However, the extent the ideas will influence policy process in the recipient country depends on domestic circumstances and institutional arrangements. There must be institutional channels to link the source of new ideas to key individuals who are in a position to translate ideas into policies, and these policy-makers must have some affinity with the proposed reforms. For example, a number of studies pointed at the influence of highly trained technocrats, individuals with graduate degrees in such subjects as economics and public administration from U.S. universities, in these policy changes (Haggard and Webb, 1994; Haggard and Kaufman, 1997; Teichman, 2004). It was also found that the level of democracy in the recipient country, its party system as well as ideologies of the political parties in power mattered: One-party dominant regimes have been found to be in the best position for the diffusion of market reforms, while new democracies faced redistributive pressures and were in the worst position in implementing such reforms (Teichman, 2004). In terms of the party systems, a highly fragmented system was not conducive to reform, while a less fragmented system was more likely to make change possible (Haggard and Kaufman, 1997). Additionally, it has been observed that the initiation of market reforms coincided with right-wing governments (Twaddle, 1996). The relative power of interest groups may also be significant in determining whether and how quickly the reform will go forward. Also, it was found that a major economic crisis was instrumental in discrediting the old economic model and gaining public support for reforms (Haggard and Kaufman, 1997; Teichman, 2004).

In this chapter, I will examine the major drivers of health care reform movement in Turkey since 1980s. I will argue that while health care reforms were initiated by domestic elites, international organizations such as the IMF and World Bank played a crucial role in policy-making by providing financial support and technical advice. The political and economic circumstances and the existing institutional setup provided the international policy networks with favorable conditions to diffuse new policy models.

The first section of this chapter will hence review the context Turkey has been in since late 1970s as a basis for understanding the major shift in health care policies that occurred

over the following decades. Actors that are involved in the policy-making will be reviewed in the second section, and the third section will discuss the most significant health care policy steps made from 1980s onwards with a focus on the health care financing reform and will provide an account of the overall process.

3.1 Political and economic context in 1980s

Turkey was ruled by a single party in the first decades following its foundation – this was the period when most of the radical reforms to modernize the country were implemented under the leadership of Atatürk. The transition to a multi-party regime was initiated in the late 1940s, yet its entrenchment into the political culture has been a long process impeded by a number of military interventions resulting in the removal of elected governments.

The 1980s is marked by one such military intervention into politics, which took place at the beginning of the decade and led to a political and economic transformation in the country. Prior to 1980, Turkish economy was characterized by inward-focused, import-substitution industrialization model, which relied on state intervention. This model stopped working well toward late 1970s, with pressures on the balance of payments caused by higher import orientation, external borrowing and rising inflation. The oil crisis and recession also caused the deterioration of the Turkish economic situation (OECD, 1980). The economy had reached a bottleneck and change was needed to bring the economy back into equilibrium (İlkin 1991, p.89).

The governing Republican People's Party had several negotiations with the IMF during the 1970s and made a number of short-term stand-by agreements, yet there was a difference of opinion between the Turkish and IMF officials in how to resolve the economic problems. The government did not support liberal policies, and as the crisis deepened, it was forced to resign.

The new government that was formed kept in contact with the IMF officials and drew up a reform package, which was shared with them. The package included the opening up of the economy to international competition, liberalization of the foreign trade regime and the financial sector, and scaling back the public sector. It was published on 28 January 1980, shared with the public in a press conference in which the Prime Minister Demirel answered a question regarding the role of the IMF in the package by stating that "the government did not act under dictation from any side" (Okyar, 1983, pp. 544-545). The package, known as 28 January (1980) Decisions, resulted in a three-year stand-by agreement with the IMF and also

an agreement with the World Bank to benefit from the "structural adjustment loans" (Kirkpatrick and Öniş, 1991, p. 13-15).

While the government of Justice Party (AP) endorsed the new economic measures, there was opposition from both society and a significant section of the parliament. The political system that would enable the restructuring of the economy was lacking. In order to restore the political and social order, the military took over the administration in September 1980. Hence the political and social environment was stabilized and it made the implementation of the new economic policies possible (Önder, 1998). After three years of military regime, democratic elections took place again in 1983 and the Motherland Party (ANAP) led by Turgut Özal, the architect of the economic reform package, came to power. Economic reforms were carried out at a high speed during the administration of ANAP.

However, as a result of policies that led foreign trade deficit combined with the impact of capital account liberalization, Turkish economy experienced a deep financial crisis in 1994 (Turkish Central Bank, 2002). Political instability and uncertainties reigned in the following years until another severe crisis occurred in 2001 - after which Turkey implemented a stabilization program and achieved successful results in terms of fiscal deficit, inflation rate and structural reforms. As a result the economy recovered, the debt-to-GDP ratio decreased considerably and the inflation rate fell to single-digits and a steady acceleration in economic growth followed. The fiscal, monetary and financial reforms were also supported by the opening of accession negotiations with the EU in 2005. Political stability allowed for the implementation of structural reforms aimed at convergence with OECD and EU best practices (OECD, 2008b). The economy has achieved a stable development, with an average growth rate of nearly 5% per year over the period 2000-2011 (OECD, 2012).

As will be explained later in this chapter, health care reforms in Turkey progressed in line with the economic developments. The radical steps made in the 1980s towards the liberalization of the economy laid the foundation for market-oriented reforms in health care. These steps were made following a major economic crisis which required foreign financial assistance and the implementation of new economic policies was facilitated by the military regime and therefore the absence of opposition. In the following decade, several reform initiatives took place but most of them have not been successful due to economic crises and political instability. Finally, the first decade of the new millennium witnessed a process of structural reform in alignment with a stable political environment and economic growth.

3.2 Major health policy actors

The major actors involved in health policy in Turkey were the government, the medical association, business representatives and international organizations.

3.2.1 Government and political parties

All political parties were banned in 1980, and only three parties were allowed to participate in the 1983 elections, of which ANAP - a center-right, neoliberal and conservative party supported by urban population - came out as the winner. Freely competitive elections resumed in 1987, which allowed the reappearance of key political figures from the pre-1980 era as their political ban was lifted. The Social Democratic Populist Party (SHP, a center-left social democratic party and descendant of Republican Party) and the True Path Party (DYP, a center-right party and direct descendant of the Justice Party) were founded by these political figures and both SHP and DYP would constitute the major competition to ANAP in the 1990s.

As can be seen in Figure 3, Turkey was ruled by predominantly center-right wing governments supporting neo-liberal economic policies in the last three decades. In the period between 1993 and 2002, no party could alone win the majority of the votes because of economic crises and corruption scandals. Several coalition governments were formed between right and left wing parties, with the 1999 government being the only coalition led by a center-left party. In 2002, the Justice and Development Party (AKP), led by Recep Tayyip Erdoğan, came out as the winner of elections, and did so in 2007 and 2011 as well.

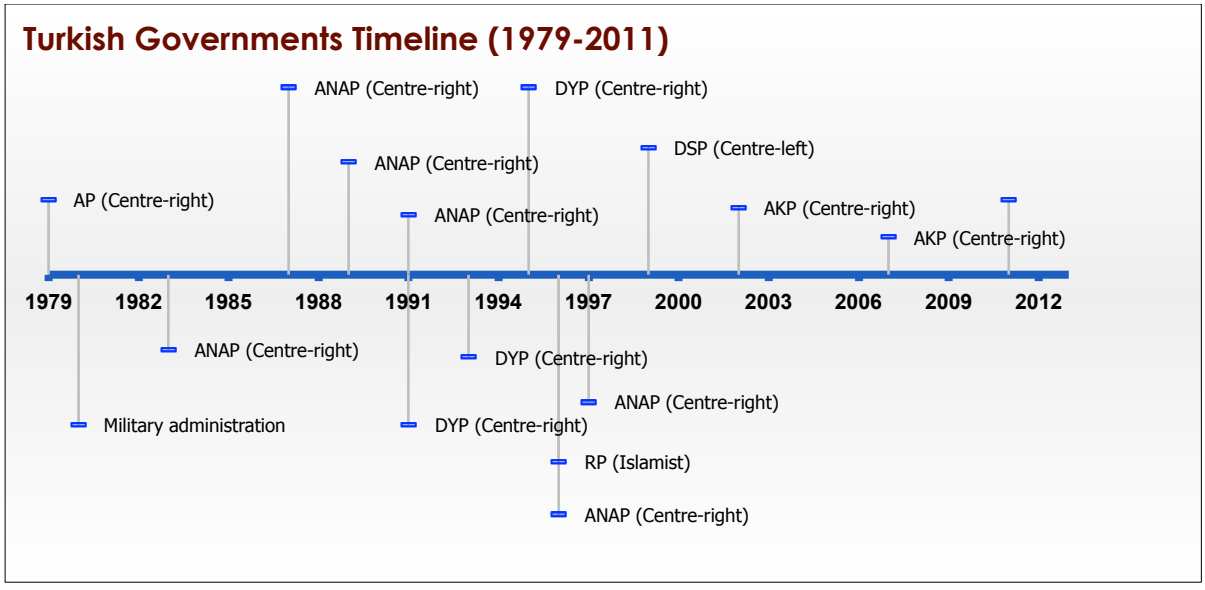

Figure 3: Governments formed in Turkey between 1979 and 2011, and their ideologies.

Two key figures in this process of reforms deserve particular attention: The first one is Turgut Özal, whose contribution to the health care reform can be attributed to his pioneering role in liberalizing the economy and introducing market elements into the health care system. Özal was the leader of Turkey's neoliberal economic transformation in the post-1980 era. As an electrical engineer with a master's degree in Economics in the US, he gradually rose to key positions in both public and private sectors. He took an influential position in economic bureaucracy in 1967; later on he worked as a consultant in the World Bank and held top-level managerial positions in the private sector. Having organic links with international networks as described above and a strong domestic support base, Özal generated confidence on the international financial community as well as the elite structures of the society (Öniş, 2004a, p.115-117).

The second key figure is Recep Tayyip Erdoğan, under whose leadership health care reforms that were on the agenda since 1980s were implemented. Erdoğan proved himself as the mayor of Istanbul in the 1990s, and formed the AKP about a year before the 2002 elections together with a group of reformist politicians of the right-wing who had roots in political Islam, yet AKP was declared by its leaders to be a secular democratic and conservative party in the center-right (Ahmad, 2005, p.181). Capitalizing on the failures of the major political parties of the 1980s and 1990s, AKP was able to gain a broad support from the Turkish electorate that was dissatisfied with the center-right parties for their widespread corruption and the center-left parties for not being able to protect the underprivileged in the society. AKP's economic policy was to enable active participation in the global market, yet at the same correcting the negative consequences of the globalization by increasing regulation as well as addressing social justice concerns, which made it appear more like an "European style social democratic party" (Öniş, 2004b, p. 4). The party displayed a strong commitment to the IMF program and the goal of EU full-membership, and so to the associated reform agenda of both, which included structural, regulatory and democratic reforms.

3.2.2 Interest groups

In order to put into perspective the role of domestic actors in Turkey in policy-making, it is necessary to point out that the Turkish political system has been characterized by a strong state tradition. The Republic of Turkey inherited some institutions and culture of the Ottoman administration, which was bureaucratic-centralist in the sense that it was not challenged by interest group politics. Instead, the well-educated bureaucracy dominated policy-making. Law and order was placed much emphasis on in the empire and the military ensured the

observance of this norm. The state in the Ottoman period as such established the "rule from above", which continued to define the relationship between the state and civil society in the Republican Turkey: A relationship in which the civil society was not included in the policy-making and refrained from challenging the paternal state (Heper, 1991, p.12-13).

In the aftermath of the 1980 coup d'état, there were strict limits on party participation in the elections, as well as restrictions on civil society organizations. In 1983, democracy resumed in Turkey, and although the paternalistic political culture continued, civil society has strengthened since then (Öniş, 1991, p. 8). Particularly, Turkey's commitment to Copenhagen Criteria, which require EU candidate countries to achieve democratic stability and protect human rights, has been a major driver of democratic reforms and had a significant impact on the strengthening of civil society (Keyman and İçduygu, 2003).

a. Turkish Medical Association

A key interest group in health policy-making in European democracies is an organization representing medical doctors. In Turkey, the Turkish Medical Association, which was founded in 1953, is the professional organization of medical doctors. However, its role in health policy-making does not equal its counterparts in European states, which is well demonstrated by the following: The 1953 Law on the establishment of the Medical Association states that the executives of the local chambers are responsible for 'encouraging the members to examine and carry out research on the health issues of the country and on the basis of this research, to express their wishes to the related health officials' (Article 28). In that sense, the law did not give the association the role of a negotiating partner in the policy-making process and the state's relationship to the medical profession was limited to consultation without involving any delegation of authority. The health policy was instead dominated by central bureaucracy, and the Turkish Medical Association did not have a significant role to play in health policy-making (Ağartan 2008, p. 156-159).

Since late 1970s, the Association has also been politically active. This raised concern from different segments of the society as the Association was engaged in social issues that were not necessarily tied to the interests of doctors. Also, the leftist ideology adopted by the Association was not supported by all of its members. In response to such criticisms, the Association defended the view that there was no dilemma between being a professional organization and assuming democratic responsibilities, yet it seems it has not been successful in creating a positive public image, which could have otherwise strengthened its position in dealings with health policy-makers: In a quote from Tanıl Bora in the history of the

association written by Füsun Sayek, one of its past presidents, it was mentioned that while Turkish Medical Association had a positive image among the unions and other professional organizations for its systematic work and ability to develop policies at detailed-levels, it was perceived by the general public as a "reactionary" and "negative" organization which was interested more in preserving the status quo than the health problems of the society (Sayek, 1998).

b. Turkish Industrialists and Businessmen's Association (TÜSİAD)

A major role in the process of reforms was played by TÜSİAD, which was founded in 1971 as a voluntary association of big industrialists in Turkey. It was a new way of organizing for the big business, which until then had to organize under the Turkish Union of Chambers where membership was enforced by the State. The activities of the association increased over the years such that it created the perception that the Association toppled governments (Arat 1991, p.139). Particularly in 1979, the year preceding the initiation of the market-oriented economic reform process and the military take-over, TÜSİAD ran a major media campaign reiterating the existing socio-economic problems and advocating the policies that should be adopted to tackle with them: Liberalization of the economy, tax reform, and support to free entrepreneurship and abolishment of government controls (Arat 1991, p. 140). The reformist Prime Minister Turgut Özal himself was a TÜSİAD member between 1974 and 1979.

TÜSİAD gave its full support to the health reform including the AKP government's Health Transformation Program, which was announced in 2003. In 2005, it published a report on health aligned with the health reform agenda of the government and supported the proposed solutions for health (TÜSİAD, 2005).

3.2.3 International actors

Turkey's position in the international system as an ally of the West during the Cold War era was a major determinant of its relations with international actors. Turkey was included in the Marshall Plan in 1948-1951, became a member of OECD and Council of Europe and joined the NATO in 1952. Having been an associate member of the EU since 1963, Turkey has also been in accession negotiations with the European Union for the last decade.

Its relations with international financial institutions also date back to the aftermath of the Second World War. Turkey has been a member of the IMF and the World Bank since 1947. Turkey has so far made 19 financial arrangements with the IMF and only the last two of them have been successfully completed. The first stand-by agreements were made in 1960s, but these were short-term. The first long-term agreement was made in 1980. The arrangements

were mostly done following economic crises.

Turkey joined the World Health Organization in 1949 and within the framework of "Technical Aid Agreements"; it carried out since then several health projects such as fight against tuberculosis, nutrition, family planning, and mother and child health. The relations with the WHO gained a momentum following the 1978 Alma-Ata Health for All Conference which reaffirmed health as a fundamental human right and identified primary health care as the key to achieving health for all. There was a significant increase in the number of WHO visits to Turkey between 1980 and 1990 (Turkish Ministry of Health, 1997). Projects continued to be run in cooperation with the WHO in the 1990s and 2000s, focusing mainly on improving health status.

A major international actor influencing Turkey's changing economic and policy spectrum was the European Union. Being an associate member since 1963, Turkey saw its future in the European Union. However, no major steps to become a member were made until later 1980s. The increasing interest in the full EU membership was linked to the creation of the Internal Market that would isolate Turkey and negatively impact Turkey's trade with European countries. It is also argued that Turkey's ambition to join the EU were behind the economic liberalization (Müftüler, 1995). Overall, Turkey's membership in the EU presented a strong external anchor for the consolidation of the reform process (Öniş, 2004a, p. 119).

Turkey's application has not resulted in accession; however, the process of integration accelerated in the 2000s. In the electoral campaign in 2002, the AKP declared its vision of full accession to the EU and gained the support of voters. Accession negotiations started in 2005. Turkey undertook reforms in many areas to harmonize its legislation with the EU and improve life standards to close the gap between Turkey and EU-average.

3.3 Health care policy process

This section will cover both the content of the reforms and policy process, since the reforms will be presented as part of the process. I will first provide an overview of the health system objectives and the starting position of the health financing system in Turkey and highlights of health status. This will be followed by the discussion on the stages of reform process, reforms, including dealing with actors. Finally, I will provide a description of the post-reform health financing system as well as public health activities in Turkey.

3.3.1 Objectives of the Turkish health system

Health care services were considered to be among the primary responsibilities of the state since its foundation. Establishing new institutions, expanding health care provision and dealing with post-war health problems were among the major objectives of the Ministry of Health in the 1920s and 1930s. Many radical changes were made in that period in order to improve the health system and the most prominent of these changes was the Law on Public Hygiene, which set up the framework for public health. In the period between 1937 and 1960 inpatient care was paid more attention and preventive services were less emphasized. The Law on the Socialization of Health Care Services, which was introduced in 1961, emphasized social justice as the main objective of the health care system. In that period, the problems faced were low health status indicators, geographic inequalities and unequal access (Tatar et al., 2011).

As will be reviewed below, from 1980s onwards liberal policies were introduced in Turkey. The 1982 Constitution referred to the establishment of a health insurance and this occupied health agenda since then. In the *National Health Policy* document, which was published in 1993, the objective of the health care system was stated as creating a healthy community made up of healthy members (Turkish Ministry of Health, 1993). Finally, the health care transformation program had the primary objectives of making the health system more effective, efficient and equitable by strengthening the stewardship function of the Ministry of Health, establishing a universal health insurance system (OECD, 2008, p.44).

3.3.2 Health financing in Turkey prior to reforms

In the countries where the health care reforms originated, such as Britain, health systems were well established with a fair level of access and quality of services, and the main focus was on rising costs mainly due to ageing population. However, the problems Turkey faced were different than the ones that urged the adoption of new policies in the European welfare states: When the series of 1980 events leading to major transformations in the country happened, the existing health care system was one of inequity: According to the OECD Health Database, only 38% of the population was formally covered by health insurance. Inequalities existed also among the insured population depending on which one of the three insurance funds they were covered by – this situation created different categories of citizenship (Buğra 2006, p.154). The system basically favored the civil servants who had access to high quality hospitals with low-waiting times, while the workers and self-employed had access to crowded hospitals with low service quality (Ağartan 2008, p. 203). There were

also significant differences between the rural and urban areas, as well as among the regions. For example, in the late 1970s the population per doctor was ten times higher in the eastern region of Turkey and in central Anatolia than in the western region of the country (Soyer 2004, p. 133). In parallel, the infant mortality has been historically higher in the eastern part of Turkey and rural areas than the western part and urban areas (Savaş et al., 2002, p. 15).

Table 1: Basic health indicators, 1965 - 1999

	Annual population growth (%)	Crude birth rate (per 1000 population)	Crude death rate (per 1000 population)	Infant mortality (per 1000 live births)	Total fertility rate	Life expectancy at birth (years)
1965–1969	2.52	30.0	13.5	158.00	5.31	54.9
1970–1974	2.50	34.5	11.6	140.40	4.46	57.9
1975–1979	2.06	32.2	10.0	110.79	4.33	61.2
1980–1984	2.49	30.8	9.0	82.96	4.05	63.0
1985–1989	2.17	29.9	7.8	65.22	3.76	65.6
1990–1994[a]	1.85	23.5	6.7	50.56	2.80	67.3
1995–1999[a]	1.62	21.4	6.5	39.02	2.45	68.6

Source: Savaş et al., 2002; State Institute of Statistics 2000, State Planning Organization 2002.

As shown in Table 1, infant and adult mortality rates have been high in Turkey. Infant mortality per 1000 live births was 82.96 on average between 1980 and 1984, and average life expectancy was 63 years for the same period. Health gains were achieved over time, however the health status has been well below OECD averages.

The health care financing has in particular been in the center of discussions from 1980s onwards and social security system was identified as a major problem. In addition to the lack of coverage for a significant portion of the population, the policy-makers pointed to the inefficiencies in tax collection, therefore arguing in favor of a system financed via contributions.

Turkey's health financing system had historically been fragmented into a variety of compulsory health insurance schemes for different populations. The largest scheme, which is Social Security Insurance (SSK), served blue and white-collar workers in the public and private sectors. The Social Insurance Organization was founded in 1964 and was financed by employee–employer payroll taxes and was accountable to the Ministry of Labor and Social Security. The Active Civil Servant Scheme, established in 1965, was financed through allocations from the government budget to institutions employing active civil servants. The Government Employees Retirement Fund, established in 1949, was accountable to the Ministry of Finance and funded from general budget revenues. Finally, a scheme for self-employed people (Bağ-Kur), established in 1971, was funded from their contributions.

Out-of-pocket payments have also been a significant source of health care financing in Turkey. Private payments accounted for approximately 30% of total health spending between 1992 and 1998 according to the estimates of the WHO European Health for All database (WHO, 2013). The coverage under private health insurance has not been significant (1% by 2003); most of the private spending in Turkey has taken the form of direct payments by patients to providers (OECD, 2008).

Hence the establishment of a general health insurance, the concept of which was already adopted in the 1982 Constitution, has become a major goal of all reform initiatives. On the other hand, unlike in industrialized countries, cost-containment was not defined as a major target during 1980s and 1990s since the public expenditure on health in Turkey has not been high enough.

3.3.3 Reform steps

It is possible to distinguish three major stages in health care reform process in Turkey following economic liberalization: The **first stage** covers the period from 1980 to 1989 - this is the period which was initiated by economic reform movement - which included the reform of the health care sector per se. There was a fundamental shift in the approach towards health care that was reflected in the new legislation and party programs, in the sense that the course of policy was altered towards commercialization of health care.

The shift in philosophy was already visible in the 1982 Constitution, which reduced the role of the State from providing to regulating in ensuring that people lead their lives in good physical and mental health. Additionally, for the first time there was a reference to the private sector and general health insurance in the Constitution. Its 56th Article states the following:

> *"...To ensure that everyone lead their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity, the State shall regulate central planning and functioning of the health services. The State shall fulfill this task by utilizing and supervising the health and social assistance institutions, in both the public and private sectors. In order to establish widespread health services general health insurance may be introduced by law."*

While in the previous 1961 Constitution, the State was attributed the role of guarantor of people's right to health as stated in the 49th Article:

> *"It is the responsibility of the State to ensure that everyone leads a healthy life both physically and mentally, and receives medical attention. The State shall take measures to provide the poor with dwellings that meet sanitary requirements."*

The change in the ideas and values concerning the role of the state in health care was common to reform initiatives in many countries. In fact, the particular ideas and values on

what the role of the state in health influenced policy choices (Lee and Goodman, 2002). This is well demonstrated in the Turkish case as the approach adopted in the 1982 Constitution was reflected extensively in the program of the 1983 government whose major objectives, along with the improvement of the health status of the country, were the implementation of a general health insurance system, achieving efficiency in secondary care hospitals, promoting private health institutions and hospitals, development of the pharmaceuticals market and ensuring competition (Soyer 2004, p. 142-143).

A major initiative in the reform process, which aimed at restructuring the health care system in accordance with the market principles, was the *1987 Basic Law on Health Services*. The law included pioneering articles, which placed the State at the same distance to both public and private health institutions, emphasizing its planning and coordinating function. Efficiency in both public and private institutions was deemed essential and the law allowed for the conversion of public institutions into private enterprises as well as the employment of contractual health care personnel. The Basic Law on Health Services also defined the first steps towards the establishment of the General Health Insurance Scheme: Those who were not covered by any health insurance were required to pay premiums unless they could not afford it. In that case, their expenses would be covered by social assistance. This was the first major step taken towards the establishment of a general health insurance, since its inclusion in the Constitution in 1982.

Although the Law had passed in the Parliament, the Constitutional Court rejected some of the articles regarding the conversion of public institutions into private enterprises, employment of contractual health care personnel as well as the centralized administration of the to-be-established General Health Insurance (Soyer, 2004).

Following this unsuccessful attempt, the government revisited the health care reform in a more systematic way by assigning the State Planning Organization (SPO) the task to carry out a Health Sector Master Plan Study to determine the essential strategies for reform. The study, which was developed through a World Bank loan and conducted by the State Planning Organization conducted in cooperation with Price Waterhouse in 1989 and 1990, introduced new concepts to the Turkish health care system (Tatar et al., 2011, p. 147). The report prepared by Price Waterhouse suggested four possible options in terms of the direction Turkish health sector reform could take:

a. Minimum coverage for everyone and improvement of existing structures.
b. National health services option based on financing via taxes.
c. Free market option based on competition in the insurance and health provision markets

and free coverage for the low-income population.

d. Reconciliation option based on collective financing in provision markets and competition.

The consultants recommended the fourth option which meant the decentralization of health care system, general health insurance to be administered by a public institution collecting premiums based on income levels, splitting health care provision and procurement (Tatar et al., 2011).

The Master Plan Study was the most significant example of cooperation with global expert communities, such as the World Bank and a British consultant company. It was also a milestone in the reform process in the sense that the health care strategies were defined based on this study. The **second stage** starts with this milestone and runs through 2002. This is a period of learning and experimenting in terms of new policy initiatives. Also, the problems of the health care system became more visible in a more democratic environment. The crowded hospitals, malfunctioning emergency services, families that were in trouble due to lack of coverage, etc. were all described in the media.

Cooperation with global players in redesigning Turkish health care system increased in the 1990s. A Health Care Loan agreement was signed with the World Bank in 1990. The First Health Project in 1991 started with the financial support of the World Bank, focusing on increasing access to basic health services and efficiency in the provision of health services and health sector management, and improving Ministry of Health's technical and management capacity. According to the agreement made with the World Bank, the role of the state would be limited to primary health services, and secondary and tertiary care would be provided by the private sector. The agreement connected to the Second Health Project was signed in 1994, sharing similar objectives with the first one. They both aimed at providing the financial resources for the planning and initiation of health care reforms.

In the same period, government took further steps in reforming the health care. One of them was the First National Health Congress, which was held in 1992 and the purpose was to review the National Health Policy. The Congress took the health reform debate to a larger platform, which included the wide-range of stakeholders. The major stakeholders such as the Turkish Medical Association voiced their criticisms on the proposed reforms. In spite of the objections related to privatization and introduction of family medicine, the draft document was published by the Ministry of Health. In the Second Health Congress further objections and alternative proposals were made, however these were not taken into consideration and the Policy document was finalized and published in 1993 (Ağartan, 2008).

Perhaps the most significant of all reform initiatives made in 1980s and 1990s was the *Green Card Scheme*, which was established in 1992. The purpose of the scheme was to provide health care services for free to people earning less than the minimum level of income and it was directly funded by the government. When health care reform occupied the agenda so intensively, the access of the poor population to health care inevitably brought about major discussions and addressing the issue in the absence of a general health insurance scheme – which could not be established since 1980s in spite of several attempts - was the election campaign promise of the government in power.

Since in this period the government has changed for almost every year and economy went through several crises, no significant changes were made in the existing health care system, although several steps were made. By the end of 1990s, Turkey had basically not implemented any of the major health care reform projects that were on the agenda since 1980s. However, the private health care sector continued to expand, two projects with the World Bank were completed and the new philosophy was taking roots in the country.

The **third stage** (2003-2013) is associated with the Health Transformation Program implemented by AKP in collaboration with the World Bank. During this period, AKP, as the single party in power, and with the goal of increasing Turkey's standards to EU average has been able to implement a series of major reforms in health care, e.g. establishment of a general health insurance scheme and family practitioner model.

The AKP government implemented a set of reforms under the Health Transformation Program (HTP), which was conceived as a ten-year reform program covering the period 2003-2013. According to the Health Minister in charge of the HTP, Recep Akdağ, this program was "inspired by the former experiences", "health reform studies of the recent years and the successful examples in the world" (Turkish Ministry of Health, 2007). Over the previous decade and during the HTP, Turkey benefited from international expertise via World Bank projects and examined developed countries' health systems. The statement of Akdağ clearly indicates that the health care reforms were the outcome of a process of learning.

The HTP was declared to address the long-standing problems in the Turkish health system: lagging health outcomes as compared to other OECD and middle-income countries; inequities in access to health care; fragmentation in financing and delivery of health services, and poor quality of care and limited patient responsiveness. The reforms mainly aimed at streamlining the health financing system; increasing managerial autonomy of public-sector providers; integrating primary care through systematized family medicine and well-functioning referral schemes. After the reform proposal was drafted, the reform team asked

for financial support from the World Bank, which has been very interested in providing assistance after performing a sector review in collaboration with the government. Over the previous decade, the Bank had emerged as a major actor, which can influence policy developments by providing analyses, ideas, and training to the professionals in the local sector (Ağartan, 2008, p. 282-284). It has been very supportive of government's initiatives and a budget of US $200 million was defined as an investment in the program.

The level of alignment and "understanding" between the World Bank and their counterparts in Turkey indicate that health policy-making in Turkey converged toward the policy models proposed by the World Bank, as the latter has been the driver by bringing new ideas and technical expertise in. In the light of the various elements of the process mentioned above, it would be too simplistic to suggest the economic reforms started in Turkey were a mere result of conditionality tying financial help to neoliberal economic reforms. The conditions set by international organizations were instrumental as an external constraint in pushing through reforms, which were favored by the government and its support base. Therefore, it would be more accurate to say the diffusion of reforms happened earlier and throughout the last decades via learning through contacts with international organizations and expert networks and accepting the global norms.

The major outcome of the HTP has been the establishment of the general health insurance. The Bill for a General Health Insurance scheme was submitted to the Parliament in 2005. Finally, the law introducing compulsory statutory health insurance for the whole population came into force in 2008. In essence, the law established the split of health care provision from health care financing. Another step was to enhance the extent of the outpatient and inpatient services in which the participants of public social security institutions were allowed to access from private health facilities. Also, the Ministry of Health was restructured with the objective of strengthening its stewardship function. Individual performance based payment systems were implemented in Ministry of Health hospitals and some health services of hospitals were outsourced.

An important topic in this period resulting from the EU harmonization process was the health promotion and prevention of diseases. The EU has a legal duty to protect public health and has developed legislation and programs to help improve help in the EU countries (European Commission, 2013). In the last decade, Turkey has reviewed its public health system and increased its efforts to align with the international and EU standards.

As reviewed above, the first decade of market-oriented health care reform can be characterized by the adoption of new concepts. These concepts were first reflected into the

Constitution and then the Basic Law on Health. As can be seen, the major actors in this stage were the business, government and international financial institutions who drove the changes in the economy and so the health sector, since the health care reform started as a by-product of new economic policies. This period did not bring about tangible results in terms of policy implementation, yet it set the new discourse and concrete steps in legislative terms, which gave way to more initiatives in the next stage. While the proposed reforms contained some aspects addressing the issues of the system, its main theme was the incorporation of the market elements into the health care. However no major changes to the system were implemented during that period.

More concrete steps were made in the 1990s along with the projects of World Bank that brought in technical expertise and more specific policy advice. After this decade of learning and experience, but also failures, the Health Transformation Program in the new millennium has been successfully implemented. Its major achievement has been the establishment of a general insurance scheme, which had been at the heart of all reform proposals in health since 1980s. Financing of health care has been a major theme in health care reform in Turkey, but the concern was mostly with expanding coverage rather than rising costs like in the European welfare states. Still, the health care reform agenda in Turkey has been very similar to the reforms proposed in other countries where the reforms were justified by increasing costs of the health care systems.

3.3.4 Post-reform health financing system in Turkey

General Health Insurance system merged all existing insurance schemes (including the Green Card scheme) under one umbrella. The current health care financing system relies on three contribution mechanisms: The compulsory social insurance contributions, which are the major source of the funding, are mainly based on payroll taxes divided between the employee and employer. Other sources of funding are state contributions (3% of all contributions) and user charges. The revenue is collected and centrally pooled by the Social Security Institution. It is then transferred to the General Directorate of General Health Insurance, which pays the providers. The revolving funds financed from social security insurances became the main financial resource of hospitals. Thus, the Social Security Institution became the single insurer that would purchase services from various providers. The premiums of those below the poverty line would be paid by the government. Various sorts of cost sharing, i.e. co-payment, co-insurance and extra-billing, is used in the system, and these have raised concerns. A second point of concern is the fact that the vulnerable segments of the population are not

totally exempted from these charges. Although, they can be reimbursed the charges, they are still requested to pay at the point receiving the service and this contradicts the principle equitable access (Yıldırım and Yıldırım, 2011).

The Social Security Institution purchases health services from public or private providers through contracts. Patients can choose their providers. The GHIS provides universal coverage and it is compulsory for residents including Turkish citizens, refugees and foreigners. The benefits package includes primary and preventive care, laboratory, rehabilitation, emergency services, organ, stem, cell, tissue transplantation, curative services, maternal services including in vitro fertilization, vaccinations, medicine, oral and dental care (excluding cosmetic treatment), medical devices and equipment (Tatar et al., 2011).

A significant feature of the system is that the GHIS scheme provides the family physician with an income based on capitation alongside salary. Additionally, the health professionals working in public hospitals receive extra payments from the hospitals' revolving fund mostly based on quantitative service criteria, which has drawn the criticism that it can distort service priorities. There are also some financial incentives for doctors working in less preferred areas to achieve a balanced distribution of doctors across the country (Yıldırım and Yıldırım, 2011).

3.3.5 Public health

The Ministry of Health is responsible for protecting and improving public health in Turkey, and in case collaboration with other sectors is needed, the Ministry of Health will lead it. For example, with regard to environmental health, the Ministry of Health cooperates with the Ministry of Agriculture and Rural Affairs and Ministry of Environment and Forestry.

In terms disease control, communicable disease reporting and notification system in Turkey was recently reviewed to align with international standards and adapted to the Turkish setting (Ministry of Health, 2004a). Ministry of Health also conducts health promotion and public health education activities focusing on vaccination, preventive health services, environmental health, food safety, emergency health care services, prevention of tobacco and alcohol usage, prevention of obesity and chronic diseases. The Ministry uses media campaigns extensively to promote healthy lifestyle, especially focusing on tobacco and alcohol usage, and obesity. In 2009, Turkey became the third country in Europe to go 100% smoke-free with a new legislation and has been able to reduce the number of daily smokers from 47% in 1995 to 27% in 2010 (OECD, 2010). Having signed European Charter on Counteracting Obesity in 2006, Turkey is also running an Obesity Control and Prevention Program.

Immunization, family planning and antenatal services are the responsibility of the General Directorate of Primary Health Care Services. Turkey now carries out the same vaccine schedule as developed countries. There are national screening programs for cancer and tuberculosis screening. Finally, occupational health services are the responsibility of several organizations in Turkey, including employers. At the national level, the General Directorate of Occupational Health and Safety under the Ministry of Labor and Social Security determines policies and monitors their Implementation (Tatar et al., 2011).

3.4 Conclusion

This chapter demonstrated that the reforms in health care were initiated by the right-wing politics in Turkey with the support of elite business structures. In addition, international financial institutions played a significant role in diffusing the ideas via the negotiations for financial support and cooperation in implementing common projects. While in the first decade of reforms high-level ideas were diffused, significant technical cooperation in health care starts in 1990s and this is the period when major reform initiatives were made. In the third decade of the reform experience, more intensive cooperation with the World Bank combined with the commitment of Turkey to full membership to the EU led to a structural process of reform and resulted in practical outcomes.

As this chapter aims to illustrate, the conditions in Turkey for international networks to diffuse new policy models were very favorable: Turkey was in a major economic crisis, which justified the big business and the right-wing politicians' demand for change to a new economic model. The intervention into democracy by the military facilitated the transition to the new model. Traditionally, civil society has not played a significant role in policy-making for until recently, but especially not in the restricted environment of the 1980s. Finally, the reform proposals were drafted or initiated by the policy elite who had links to international networks or had affinity towards proposed solution.

Health care financing has been the focus of all reform initiatives in Turkey since 1980s. After many attempts, a universal health insurance system was finally established in 2008. The major characteristics of the new financing system are the single-insurer model, universal coverage, extensive standard package for all citizens and cost-sharing.

4. Czech Republic: Health policy development (since 1990s)

After the collapse of the communist regimes in Central and Eastern Europe in 1989, the post-communist countries embarked on a process of rapid transformation that brought about massive changes in the state structure and in the form and nature of the economy. Convinced of the need to change the economic policy, the governments dissolved institutions responsible for planning and introduced liberal economic reforms. The ideas of Washington Consensus, focusing on policies such as financial liberalization, free trade, cutting public spending, tax reform and privatization, were transmitted to countries transitioning from central planning to free-market capitalism via international financial institutions (Heywood, 2011, p. 90).

The health care reform was established as a major priority by the post-communist government in the Czech Republic and the main component of the reform was the transition from a centralized state-owned health care system to a social health insurance system. The health care reforms were justified by the structural deficiencies of the communist-type health care system and economic regime under which health was not a high priority sector unlike heavy industry or defense (Beckmann and Nemeč, 1997; Vepřek, Papeš and Vepřek, 1995).

In parallel with the previous chapter, which dealt with the health care reform in Turkey, the present chapter will be devoted to examining the driving forces of the health care reform in the Czech Republic following economic liberalization. As will be demonstrated in the first section of this chapter, the political and economic contexts, as well as the legacy health systems in Turkey and the Czech Republic were different from each other. However, as the argument will suggest, the reform movement in both countries shared the common characteristic of being influenced by international agencies, although different dynamics were present at domestic level. In particular, the interest groups of health sector played a major role in adopting the new policies unlike their counterparts in Turkey that opposed the reforms. These interest groups will be discussed as part of the second section dealing with actors. The third section will address policy process that resulted in a new health care system in the Czech Republic, and its major component, the health financing system, will be described in the fourth section.

4.1 Political and economic context prior to reforms

A main feature of the political system in Czechoslovakia was the monopoly of the Communist Party over political and social control, which meant that the preferences of the

party elite determined state priorities and choices among policy options. Command economy was adopted by the Czech Republic like in the other Central and Eastern European countries. This means that the state governed production and trade activities and developed plans. The state also owned the land, production enterprises and institutions related to the service sector, such as health facilities, pharmacies (Davis, 2009, p. 26).

Following the Velvet Revolution in 1989, Czechoslovakia became a multi-party parliamentary democracy and entered into a process of sharp economic transformation in early 1990s. Post-communist economic recovery was implemented by development of the private sector, particularly in the trade and services areas, increased exports to industrialized nations, devaluation of the currency and control of inflation. In 1992, the country split into Czech and Slovak Republics.

Between 1993 and 1996, a very rapid economic growth was achieved (OECD, 1998). At the end of 1996, approximately 80% of the Czech Republic's large companies had been privatized. By 1997, the economic growth slowed down and the Czech Republic went into a recession, which lasted through 1999. The 1997 currency crisis was mainly due to “easy access to credit from state-controlled banks”, “largely unregulated capital markets and confused corporate governance” (OECD, 2000). By the time the country joined the EU (2004), economic growth had picked up again, rising from 2% to 6% between 2002 and 2005 (OECD, 2006).

4.2 Major health policy actors

Following the Velvet Revolution, a process of reform and democratization was initiated in the Czechoslovakia. The transformation of the health care system followed this process. The communist health institutions (Regional and District Institutes of National Health) were dismantled and professional medical associations were founded in 1990s (Rokosová et al., 2005). The role of these associations will be reviewed in the below section, as well as other actors such as the government and international organizations.

4.2.1 Interest groups

A small group of activists within the Civic Forum committee initially represented the interests of health professionals. They published a set of principles for health care reform in 1990 that included abolition of state monopoly on health care, establishment of health insurance with universal access and competition among health care providers (Orenstein, 1995).

In 1991, the Czech Medical Chamber Act (No. 220/1991) established the Czech Medical Chamber, Chamber of Dentists and Pharmaceutical Chamber. The membership of the Czech Medical Chamber is compulsory. As stipulated in the Act, the Medical Chamber is responsible for monitoring and improving the quality of professional care as well as representing physicians in negotiations with both the governments and insurance companies. The Union of Doctors was very influential in the policy changes of early 1990s and there were some obvious conflicts of interests in the first phase of reform such as the introduction of fee-for-service payments for doctors (Lawson and Nemeč, 2003).

Unlike in Turkey where the scope of health professionals' responsibility was much narrower as defined by law, the legislation in the Czech Republic enabled the Czech health professional associations to play a very significant role in health-policy making, such that: "After the establishment of professional chambers, their representatives were able to dominate the health policy-making and implementation process, to a significantly greater extent than in other (Central European) countries . . . (therefore,) the influence of citizens over health policy during 1990-96 was minimal-practically zero" (Háva and Kružik, 1997, noted in Lawson and Nemeč, 2003).

Hospitals in the Czech Republic were also influential actors over the course of health policy. They promoted ideas of health insurance and fee-for-service payments. Additionally, pharmaceutical companies are significant players in Czech health policy (Lawson and Nemeč, 2003). With regard to patients, their position as actors of health policy has been weak as they are not informed and access to data is limited (Háva, 2010). The situation seems to not have significantly changed since 1991 when a public survey was conducted and revealed that no more than 3% of the respondents were informed or interested in the changes that were happening in the health care system at the time (Bojar, 1992, p. 2465).

4.2.2 Government and political parties

Since the split of Czechoslovakia, the Czech Republic has been ruled by governments alternating from center-right to center-left, as can be seen in Figure 4. In the aftermath of the Velvet Revolution, the Civic Democratic Party (ODS) prevailed in Czech politics and their political agenda placed most emphasis on economic reform and limiting the role of the state in social policy. The right-wing governments of 1992-1998 period maintained reserved attitudes towards EU enlargement and this led to considerable gaps in the EU accession effort of the country.

This picture was changed when the government led by the Czech Social Democratic Party

(CSSD) was formed following the elections in June 1998. During this period, the European Social Charter was accepted by the Czech Parliament in 1999. The political agenda of this center-left government was based on the idea of a socially and environmentally orientated market economy. However, the budgetary constraints, the minority position of the government causing legislative delays had negative impact on the implementation of the government program. In 2002 elections, the Social Democrats were in power again developing a pro-European policy and speeding up the EU-accession preparatory process (Potůček, 2004).

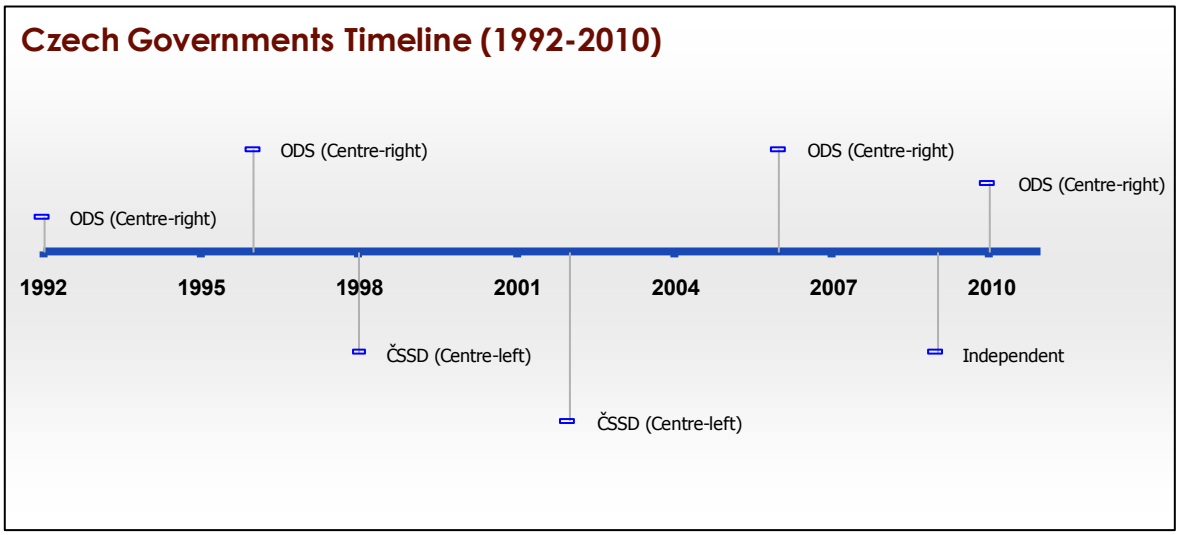

Figure 4: Governments formed in the Czech Republic between 1992 and 2010, and their ideologies.

4.2.3 International actors

In the bipolar world of the Cold War period, Czechoslovakia was positioned in the Eastern bloc and was part of the eastern alliances such as the Warsaw Pact. These alliances were dissolved in the post-cold war era and the Czech Republic was included in the United Nations and Bretton Woods system of the West. The World Bank and the IMF governed by the Washington Consensus were influential actors and had a considerable space to act. After 1989, several IMF and World Bank missions visited Czechoslovakia with plans to provide technical assistance, new projects and policy support. Encouraged by international financial institutions, Czechoslovakia embarked on a shock therapy transition from central planning to capitalism. The Czech government received a Structural Adjustment Loan from the World Bank and signed three stand-by agreements with the IMF between 1990 and 1993.

The agreed policy measures between the Czech government and international financial institutions include tax policy, liberalization, privatization, enhancement of competition, banking sector reform and energy efficiency reform. Although the assistance for

macroeconomic stabilization and broad economic reform were critical in the early years of the transformation, the role of the financial institutions has been smaller than originally expected (Drábek, 1994). The third stand-by was suspended at the request of the Czech government that found the country's financial position did not require additional resources and the debt was pre-paid. In fact, Czech government, represented by Václav Klaus, was skeptical towards international financial institutions. He was particularly critical of the World Bank and the IMF and questioned the quality of the advice asking the Bank's country director, when finance minister of the Czech Republic: "Why should we pay hard money for soft advice?" (Noted in Ramachandran, 2006, p. 83).

The role of the EU has not been significant in this period where the focus was on economic reform and social policies were undermined. As a result, the Czech Republic and other New Member States entered the EU with their health, social, and employment policies not developed enough to cope with the demands of the Lisbon Strategy, which was executed only since 2004. Although the EU has not been influential in shaping domestic policies of welfare in the 1990s, it has been helping pushing social policy issues higher on the agenda since the start of the twenty-first century (Potůček, 2004).

4.3 Health policy process

As in Chapter 3, this section will present both the content of the reforms and policy process, since the reforms will be presented as part of the process. First, an overview of the health system objectives and the starting position of the health financing system and highlights of health status will be provided. This will be followed by the discussion on the stages of reform process, reforms, including dealing with actors. Finally, I will provide a description of the post-reform health financing system as well as public health activities in the Czech Republic.

4.3.1 Objectives of the Czech health system

The basic principles of the Czech health system are solidarity, universality and equity (Rokosová et al., 2005). The reforms that took place in the early 1990s focused on dismantling communist institutions, establishing a new health insurance system and privatizing primary and outpatient specialist care although the objectives of these reforms were not clearly stated. The Czech Republic returned to its pre-Second World War Bismarckian roots and reintroduced a social health insurance system shortly after 1989. The main priorities of the government from 2007 onwards have been economic stabilization,

modernization and improving the quality of care (Bryndová et al., 2009).

4.3.2 Health financing in the Czech Republic prior to reforms

The Czech Republic shifted from social insurance to state budget financing after 1945. Under the command economy, health care system was centrally administered and funded from the state budget. Funding from the Ministry of Finance went to the regional and district national committees. The Ministry of Health did not have a significant financial authority. Patients were automatically assigned as a GP and a specialist or hospital, and on the basis of residence. Health services were usually provided without direct payment. The system was labor-intensive with high-ratios of health personnel to patients.

Since the Second World War, the life expectancy grew in the Czechoslovakia. Unlike post-war level rose to 1960 in men by 7.6 years and for women by 5.1 years (men 67.6 years, women 73.1 years). At this time, the CSSR life expectancy was comparable to that of most Western countries. The Czech Republic achieved significant progress in decreasing infant mortality, average rate was 11.3 in 1989-1991, which was close to USA (9.4) and France (11.3). On the other hand, adult mortality from diseases such as circulatory and were higher than in Western countries.

Health status of the Czech population was therefore found unsatisfactory compared with the health status of populations in Western countries. This was mostly a result of lifestyle and environmental factors, which contributed to 70-80% of health status, while quality of care only partially, influenced the health status of the Czech population (Vepřek et al., 1995, p. 45).

Table 2: Key health indicators in the Czech and Slovak Republics, USA and France (1946-1991)

	Average 1946–48		Average 1960–62			Average 1989–91		
	ČSR	USA	USA	France	ČSSR	USA	France	ČSFR
Mortality[a]	14	10.1	9.4	10.7	9.2	8.6	9.3	11.7
Infant mortality[b]	110	32.7	25.2	27.1	22.7	9.4	7.3	11.3
Life expectancy:								
Men	60	64.5	67.6	67.2	67.6	71.6	73.1	67.3
Women	68	69.8	74.4	72.9	73.1	78.6	81.5	75.5

Source: In Vepřek et al., 1995, "Molnosti diagnozy" 1992; Historical Statistics of the USA 1961.

4.3.3 Reform steps

The Czech health care system went through significant changes since 1990s. The first half of the nineties was rich on reform measures focusing on market-oriented reforms. The main elements of reform were lifting of state monopoly on health services, free choice of physicians, introduction of a public health insurance model and a fee-for-service payment (OECD, 1996).

The health care reform was at first led by a small group of activists within the Civic Forum committee of health professionals. The principles they published reflected the social-liberal views of the Civic Forum committee in that they wanted to maintain state guaranteed access to health care, yet at the same time allowed for competition among providers and free choice of doctors and hospitals. This group formed the core of the Ministry of Health Working Group for Reform and they prepared a proposal for reforming the health care, which was published in May 1990 for public discussion. This proposal formed the basis for the reform document "Proposal for a New System of Health Care", which was accepted by the government in December following a process of debate and consultation with health care professionals and associations, and within the government (Potůček 1994, noted in Orenstein, 1995).

In 1991, the General Health Insurance Fund was founded. It started its activities in 1992, when it began to reimburse health care providers. The Act No. 550/1991 Coll. on general health insurance was adopted in 1991 and supplemented by Act No. 592/1992 Coll. on premiums for universal health insurance. The health care system has in this way moved towards a compulsory health insurance model, with a number of insurers financing health care providers on the basis of contracts. It was inspired by some aspects of the pre-war health insurance system, as well as by the present systems in Germany, Austria, and the Netherlands (Bojar, 1992). There were up to 27 health insurance funds at one period in the mid-1990s. At the beginning of 2000, the number had decreased to nine as many of them experienced financial problems: The fee-for-service model created incentives for an increasing number of contracts with the insurance funds, which led to an uncontrolled growth of health expenditure.

When the General Health Insurance Fund began to accept payroll tax contributions in 1993, a variety of other funds competed with it for contributions. The insurers tried to attract healthier and younger individuals and this created the risk of General Fund getting into high deficits. Therefore, the state introduced a more sophisticated system of redistribution among the funds (Výborná, 1995).

In 1993, privatization was initiated, especially in outpatient care. The law on health care in private health care facilities adopted in 1992 allowed the establishment of private practices for physicians. The privatization started in 1995 – a significant number of doctor clinics, pharmacies and dispensaries were privatized.

Unlike in Turkey, the health financing reform was implemented in a very short period of time following economic reforms. These reforms did not follow projects ran in cooperation with the World Bank like it was the case in Turkey. In fact, as explained earlier in this chapter, the financial assistance received from the IMF and World Bank had a short duration, they addressed a wide-range of economic reforms and not health in particular, and the government was reluctant to receive further assistance, meaning the role of these institutions became limited. However, at the onset of the reforms, Czech health policy-makers made use of international expertise and experience in their policy choices as demonstrated in the following statements of Health Minister Bojar:

> *"The Czech Republic is at a unique crossroads where it may choose the best and avoid the worst of that found in other countries. Open borders have afforded many new opportunities for international collaboration. Short study trips abroad have enabled Czech medical professionals to train using new technologies and techniques...*
>
> *...Most relevant perhaps have been the Western experts who have offered expertise, advice, and experience in helping to guide the transformation process. Simultaneously, Western consultants have enjoyed the opportunity to put theories and practical knowledge to use in the Czech Republic." (Bojar, 1992, p. 2466).*

In the spring of 1997, the Ministry of Health proposal for restructuring the network of acute hospital beds, where their number should be reduced to 5 beds per 1000 inhabitants (in 1995 there were 7.2 per 1,000 inhabitants beds). Another reform period before the accession to EU was devoted to a public administration reform and to the decentralization of acute hospitals. Although the pre-accession period was an opportunity to modernize and update health care legislation, priorities were oriented towards the further autonomy of the hospital sector. (Háva, 2010).

Another wave of reforms was introduced after the 2006 parliamentary elections resulting in a right-oriented coalition government. The leading political party (ODS) prepared the Public Budgets Stabilization Act, which was passed in August 2007 and included a set of measures aimed at the Czech health sector. These measures included introduction of user fees, establishment of annual ceiling on health insurance contributions. The purpose of introducing user fees was to reduce the number of outpatient contacts per person in the Czech Republic, which was the highest in the WHO European Region (Bryndová et al., 2009).

The reforms became a sensitive political issue in the Czech Republic causing debate in the

Parliament, media and the general public. The discontent with the reform was reflected in regional elections later in 2008 and resulted in decline in votes for the government (Háva and Mašková, 2009). In January 2009 there was a change in the position of Minister of Health and February 2009, the reform bills withdrawn in the Chamber of Deputies with the fact that they been finalized.

The above-described health care reforms were characterized by strong interests on the part of the health care providers and administrators of the health insurance system. But more attention to the health care system was also paid by entrepreneurs from other sectors and countries, financial markets, and health care policy was influenced by these different groups of actors, with different aims and objectives. After 2000, during the last reform period (2006-2008) an increased influence of neo-liberal measures and principles could be observed (Háva, 2010).

Háva and Mašková (2009) found that a similar reform agenda existed in all Visegrad countries. They argued that health policy was influenced by a range of actors including international financial agencies, entrepreneurs and right-wing politicians. They also drew attention to the profit-driven nature of the reform objectives, instead of addressing existing health gap problems, organization of primary health care services or quality management.

As discussed in this section, the transformation of Czech health care system happened very fast, like the rest of "shock therapy" transition. In particular, health financing system was changed in the very first years of transition. The reforms brought fundamental changes by reducing the role of the state in health and creating a market-oriented system. Given the short period of time, no long-term projects in collaboration with international organizations such as the World Bank were made like in the case of Turkey. On the other hand, policy-making in the Czech Republic was guided by international expertise.

In the second half of 2000s, there were more profound reform initiatives aiming for further diminishing the role of the state in health care and increasing the share of patients' burden in health expenditures, as well as further privatization.

4.3.4 Post-reform health financing system in the Czech Republic

In early 1990s, the Czech health care system transitioned from being a tax-financed system to one financed through health insurance (Rokosová et al., 2005, p. 29). Based on solidarity and equity, health insurance system is funded by the contributions of individuals, employers and the State. There are currently nine health insurance companies. The largest health insurance fund is the GHIF, which covers 68% of the population (2002). The fund is guaranteed by the State and it is legally obliged to insure everyone. Each insurance company collects the contributions (payroll taxes) separately.

Since 1990s, the pooling arrangements in the Czech Republic have been revised several

times to improve the sustainability of the financing system. The issue was that the insurer companies were organized by sectors and their members were mostly employed citizens, while the retired people stayed with the General Fund and that would cause the financial deterioration of the General Fund. Therefore, some risk adjustment features were introduced to enable the pooling of funds across the insurers. Later on, a more sophisticated risk-adjustment formula was introduced in 2003 to increase financial protection and equity. (Kutzin et al., 2010).

Since 1992, nine statutory insurance funds are the health purchasers. The health insurance funds have contractual agreements with the private ambulatory care providers and public hospitals (Rokosová et al., 2005, p. 15-20). Primary health care was first paid for according to salaries, then on a fee-for-service basis, and now is paid for by means of capitation. A bonus is paid in addition to the capitation rate if cost containment targets are met.

The health insurance covers the whole population, as well as the permanent residents and foreign nationals employed by the Czech Republic based organizations. Among the services fully or partially covered by the health insurance are preventive services, diagnostic procedures, ambulatory or curative care, drugs (generic) and medical devices, medical transportation services and spa therapy.

4.3.5 Public health

Lately it is emphasized that health care and its level is not the only factor contributing to the overall health of the population. More and more importance is attributed to lifestyle and socio-economic factors. The future of better health status of the population is seen to focus on programs that promote public health and prevention of disease.

The Ministry of Health conducts public health activities through National Institute of Public Health (SZU), Regional Public Health Authorities and Regional Institutes of Public Health. The social health insurance covers preventive care services such as compulsory vaccination, preventive examinations by GPs and gynecologists and cancer screening programs.

The vaccination package is quite extensive and vaccination rates for major immunizable diseases vary from 95% to 99%. The National Health Program was accepted in 1995 as a long-term public health strategy. Its major goal has been to encourage people to their health. Laws on restricting smoking in public places and regulating advertisements were implemented over the last decades (Bryndová et al., 2009).

4.4 Conclusion

This chapter focused the transformation of health policy in the Czech Republic since 1990s. The major reforms in health care were implemented in the early years of the transition, in particular the health insurance reform. Although international financial organizations were involved in the economic transformation of the Czechoslovakia like the rest of the Central and Eastern European countries, their influence was less than expected. However, the Czech policy-makers were guided the expertise and advice of the Western experts. Additionally, professional health associations played a major role in pushing through these reforms.

For the Czech policy-makers the decision to establish a social health insurance and its implementation were done quickly – which must have been facilitated by the country's experience with such a system before communism. The reforms also benefited from the general public support for reforms since the revolution, but not necessarily for specific policies of health. In fact, only a very small segment of the population was informed or interested in the changes of the health care system.

From mid-1990s to mid-2000s, the pace of reform was slow in the Czech Republic. In mid-2000s, new reform initiatives caused fierce debates in the country for they represented a vision to enhance the commercialization of the health care. These initiatives coincided with right-wing politics. In the end, the reform proposal was withdrawn due to strong opposition to it. Health care financing has also been a major topic of reform in the Czech Republic, and perhaps more than or in different ways than desired. Particularly the later reform initiatives represented mostly the economic interests, instead of addressing the health problems in the society.

5. Comparison

Policy diffusion studies often investigated the incidence of the spread of new policy adoptions in countries with geographical proximity, e.g. pension reform in Latin America (Weyland, 2005) or tax reform in Central or Eastern Europe (Willis, 2010). In that sense, the cases of the Czech Republic and Turkey might seem as a peculiar selection since the two countries are not neighboring each other and they are not the obvious choices for comparison in studies dealing with a small group of countries.

Yet the purpose of this study is not to investigate a spread of ideas from the Czech Republic to Turkey or vice versa and therefore the neighboring effect, the level of political and economic relations or the historical ties between the two countries are not deemed to explain the health care reform process both countries embarked on in the last two or three decades. Instead, the two countries are compared from a global perspective which suggests that states increasingly operate in a context of global interdependence and interconnectedness resulting from a substantial growth in transnational flows and transactions – movement of people, goods, money, information and ideas. The global setting is strengthened by the emergence of global governance since 1945, reflected in the growing significance of international organizations such as the United Nations, the IMF, OECD, World Bank or the EU in the world politics (Heywood, 2004).

From that perspective, the Czech Republic and Turkey are considered as the recipients of ideas which spread globally via networks of transnational actors formed of epistemic communities, interest groups and policy-makers. It is suggested that while international organizations play a significant role in the diffusion of policy ideas, domestic conditions determine which policy choices will be made.

In this chapter, I will compare the two countries' policy choices as a result of the interplay between domestic conditions, interests and a global diffusion of ideas. Furthermore, I will provide an assessment of progress made with regard to the achievement of health objectives over the period 1990-2010.

5.1 Diffusion of health care reform ideas in Turkey and the Czech Republic

As demonstrated in Chapters 3 and 4, Turkey and the Czech Republic had different political and economic contexts and health systems at their starting point of reforms. Their

original economic systems were very different from each other in that the Czech Republic was transitioning from a communist system while Turkey, although inward-looking and state-subsidized, had a capitalism oriented economy. The health financing systems in the two countries were also different from each other. In the Czech Republic, there was universal coverage and the system was state financed. The distribution of health services was more equal than in Turkey. In Turkey, the system was financed via taxes and employer contributions, however a majority of the population did not have any coverage. Also, major differences were observed among the regions, especially between the eastern and western parts of the country.

In Turkey, the health care reform followed the economic liberalization, which occurred in the early 1980s. Market concepts were introduced in the political discourse and legislation concerning the role of the state in health care, and financing and provision of the health care. The international organizations played a significant role in the diffusion of reforms in Turkey as the economic liberalization was assisted by the IMF and World Bank loans. In addition to that, throughout 1990s and 2000s, Turkey conducted several health projects with the World Bank and received financial assistance and technical advice. This has developed as a learning process for the Turkish policy-makers and experts, and while the new concepts were reflected in the government plans since the early stages of reform, they could not be implemented until mid 2000s.

In the case of Turkey, the economic policies adopted in 1980s, which eventually included the health care sector were influenced by global forces. They were diffused via agreements with and policy guidance of international organizations and global policy circles. However, to say that the policies were imposed by international financial institutions, would be misleading. Instead, the demand for change came from domestic actors. The existing system had stopped working in the new global conjuncture and the internal sources of profit were consumed. There was a need to change the policies to exist in the new world system and the way of doing that was to adopt the policies promoted by the leading countries.

In terms of health care reform, it is significant that policies proposed in that period in Turkey shared common themes with more developed countries' reform packages, which focused on efficiency while the major problem of Turkish health care system was inequity. This suggests that the new health care policies were not specifically designed to address the real country-specific issues; rather the new policies were derived from other country's reforms. The reform movement took the form of "rule from above" in which the state and business were participants of the decision-making process. As such, major obstacles occurred

in the enforcement of new laws and implementation of reforms for about twenty years following the first reform steps.

There was a contrast with the Czech Republic where the major health reforms took place in a much shorter period; the reforms started in the context of transition to a capitalist economy and economic liberalization in 1990s and were implemented in the first half of the decade. For example, the social health insurance law in the Czech Republic was adopted in 1992, while in Turkey it was adopted in 2006. This demonstrates that hypothesis #2 is true. While the IMF and World Bank were involved in the transition process and provided financial support and advice to the Czech Republic, the reforms were implemented much quicker in the Czech Republic than in Turkey. On the other hand, in both countries reforms were guided by a network of experts and transactional actors. It is therefore demonstrated hypothesis #1 is also true for both countries.

A number of different dynamics were at play in the two countries and these can help explain the difference in the timing of implementation of reforms. In Turkey, the reforms were led and supported by the center-right parties and business, but opposed by the Medical Association, and this was probably influential in slowing down the pace of reforms. This is a major difference between Turkey and the Czech Republic, since in the Czech Republic health associations were strong supporters of reforms. This finding suggests that hypothesis #4 is true for the Czech Republic, but false for Turkey.

The Czech experience with a social insurance system before the communist regime might have facilitated the decision making process of the policy-makers. For Turkey, the experimentation with the new financing policy was more complex and it required a long learning process, strong political commitment and political and economic stability, which was only reached in mid-2000s.

5.2 Health financing systems

The health financing systems established in Turkey and the Czech Republic after the reforms have the following common characteristics: Essentially, they are both social health insurance systems which are funded mainly by employee-employer contributions. The coverage is universal and benefit packages are quite extensive. In both systems, the insurance companies can make contracts with both public and private providers. On the other hand, while there is only one insurance company in Turkey, which collects and pools the revenue, in the Czech Republic there are competing insurance companies organized by sector. There

are also differences in the varieties of cost-sharing and payments to physicians. Overall, it can be said that the two countries moved to a - principally - similar system of financing after the reforms, however there are differences in its adaptation in the two countries. In that sense, with regard to hypothesis #3, there has been convergence to some extent between the two systems.

Having gone through a major process of reform at different stages and under different dynamics, whether the two health care systems made progress in alignment with the key objectives of health financing is a matter of interest. These objectives are derived from the principles that WHO members of the European Region agreed and relate to the broader goals of health care systems. The two essential objectives are promotion of universal protection against financial risk and promotion of a more equitable distribution of the burden of funding the system (Kutzin, 2009).

Fiscal capacity is a key contextual factor for supporting the extent to which countries can achieve health financing policy objectives, since the amount that a government spends on health depends partially on its overall fiscal constraint and partially on decisions made with regard to priorities. Therefore, I will first review the fiscal context for both countries. The fiscal context refers to a government's current and expected future capacity to spend. A good measure of the current fiscal context is the ratio of public expenditure to GDP (Kutzin, 2009).

As can be seen in Figure 5, the government spending as percentage of GDP has been declining from 53% to 44% between 1995 and 2010, which shows that the fiscal space was contracted in the Czech Republic. This means, the fiscal capacity for health spending was lowered. Essentially, the public health expenditure as percentage of GDP went down from 6% in 1995 to 5.8% in 2008, which is aligned with fiscal contraction, and from 2008 onwards went up and settled at 6.6% of GDP in 2010.

In Turkey, the fiscal capacity increased from 18% in 1995 to 40% in 2010, while still below the Czech Republic (44%) and EU-15 (50%). At the same, health spending as a percentage of government spending increased from 11% in 1995 to 13% in 2010, which indicates a significant increase in government spending on health in combination with the increased percentage of government spending. This is also reflected in the public sector spending on health, which increased from 1.8% in 1995 to 5% in 2010. Although, there is an increase, the level of spending is below the Czech Republic, which spends 6.6% GDP and EU-15 (8.2%).

With regard to total health spending, the Czech Republic spent 7.9% of its GDP on health increasing from 6.7% in 1995. In Turkey, total spending increased from 2.5% in to 6.7% in

2010. Total health spending in the Czech Republic grew, in real terms, by an average of 6.2% per year between 2000 and 2009, but it decreased by 4.1% in 2010. This reduction in health spending in 2010 was mainly due to cuts in administrative costs and postponement of investment plans. Both countries are behind the level of spending in EU-15 (10.6%).

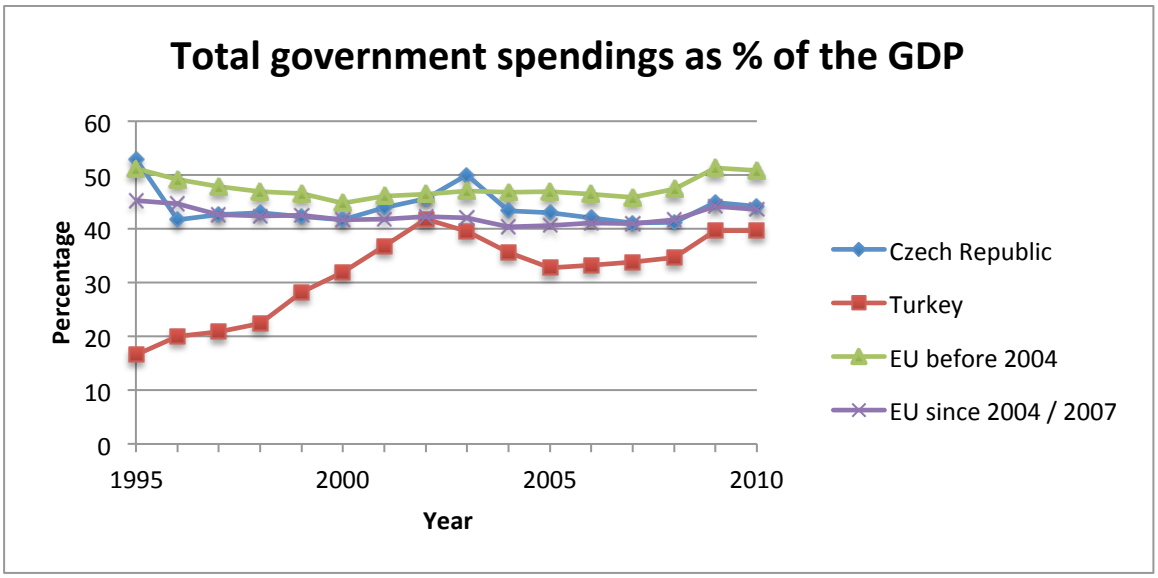

Figure 5: Total government spendings as % of the GDP

Source: WHO European Health for All Database, 2013.

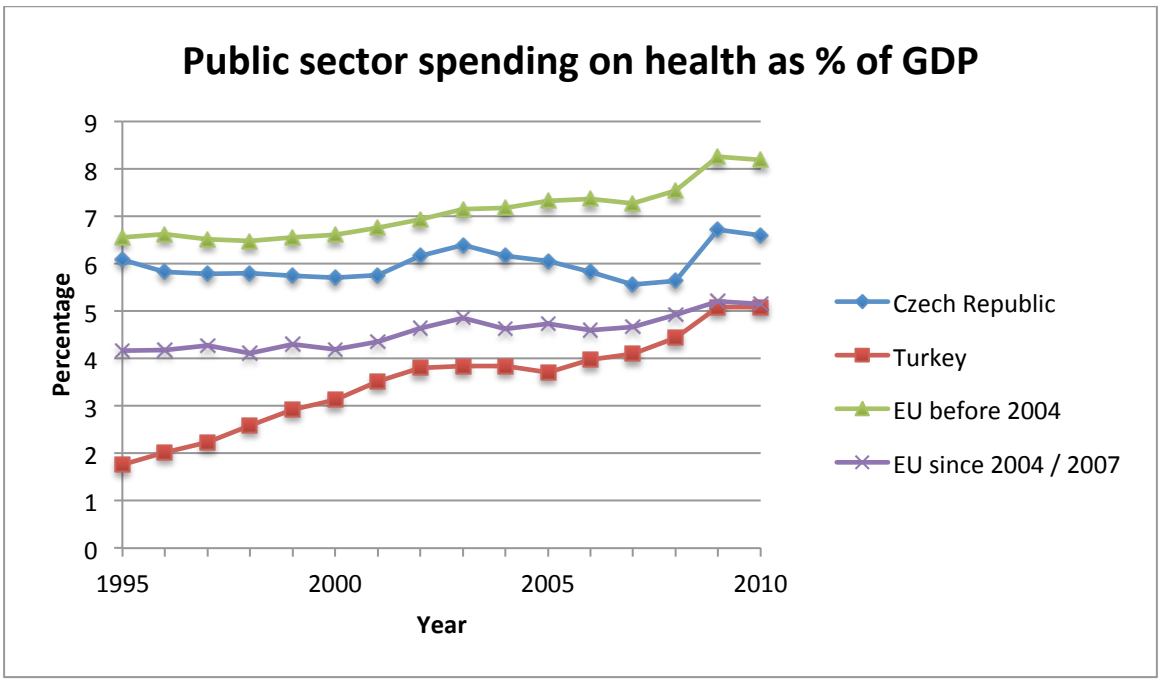

Figure 6: Public sector spending on health as % of GDP

Source: WHO European Health for All Database, 2013.

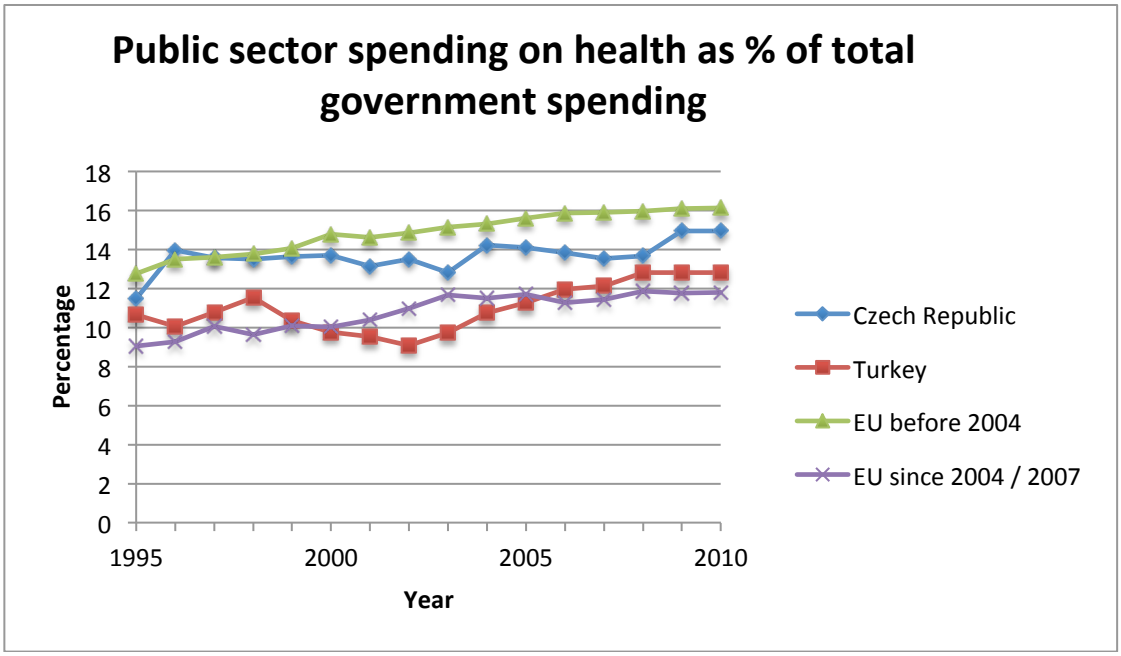

Figure 7: Public sector spending on health as % of total government spending

Source: WHO European Health for All Database, 2013.

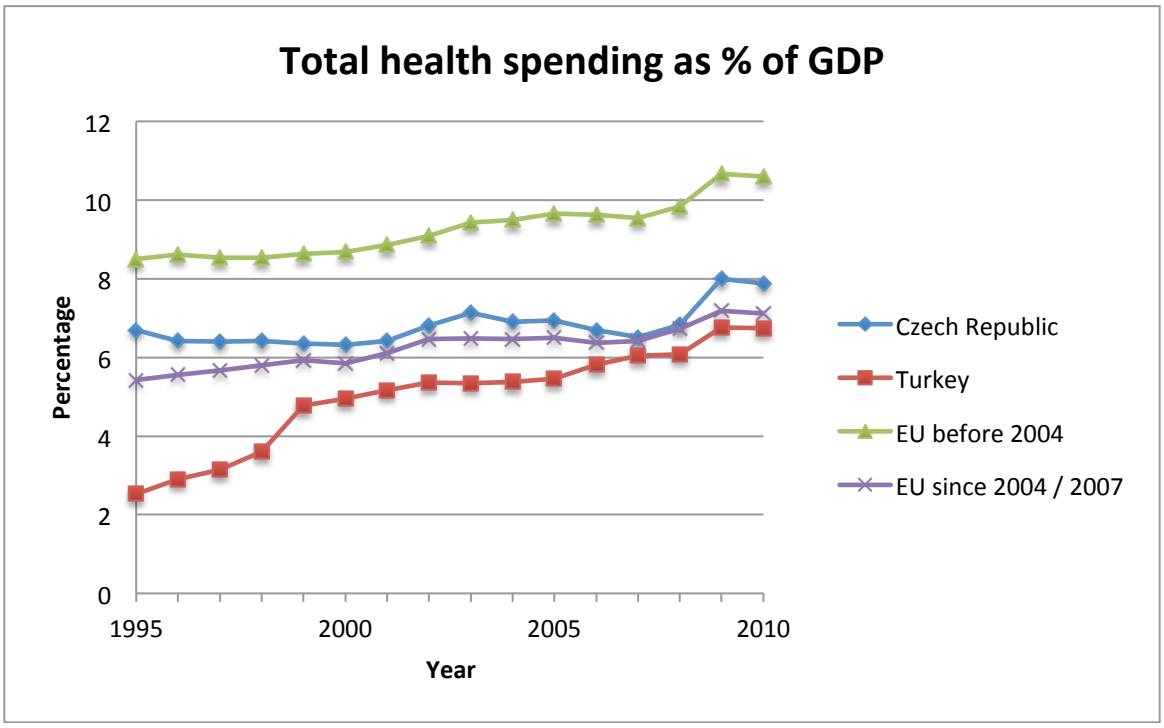

Figure 8: Total health spending as % of GDP

Source: WHO European Health for All Database, 2013.

Table 3: Key health financing indicators in 2000 and 2010 for the Czech Republic and Turkey

	GDP per capita in international $		Public spending on health as % of GDP		Private health spending as % of total health spending		Total government spending as a share of GDP (fiscal context)		Public health spending as a % of government spending (priority)	
	CZE	TUR	CZE	TUR	CZE	TUR	CZE	TUR	CZE	TUR
2000	5.725	4.189	5,7	3,1	9,7	37,1	41,7	31,9	13,7	9,8
2010	18.789	10.050	6,6	5,1	16,3	24,8	44,1	39,6	14,9	12,8

Source: WHO Health for All Database, 2013.

5.2.1 Financial protection and equitable funding

The indicator chosen to measure financial protection is the level of out-of-pocket payments. International evidence suggests that there is a strong correlation between out-of-pocket payments as a share of total health spending and the percentage of families that face catastrophic health expenditure. This means that, relative to their capacity to pay, the poor should not pay more than the rich. International evidence drawn principally from high-income countries suggests that compulsory pre-paid sources (general taxation and payroll contributions for compulsory health insurance) tend to be more equitable. Voluntary health insurance is less equitable and out-of-pocket payments are the most regressive (Kutzin et al., 2010).

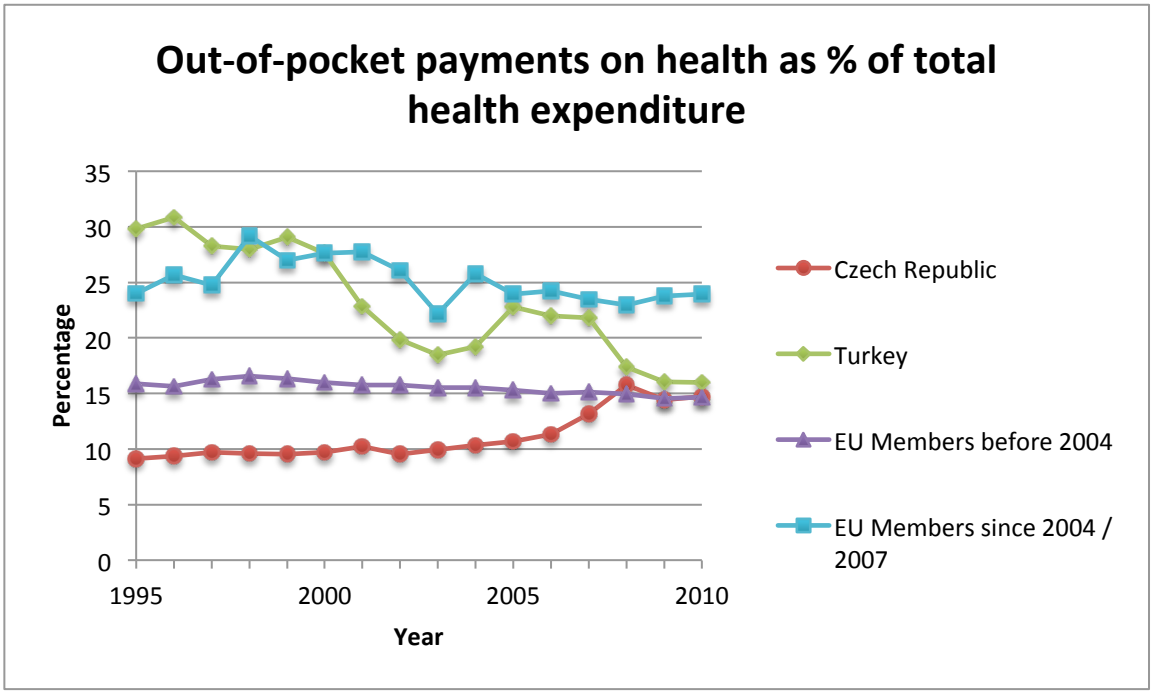

Figure 9: Out-of-pocket payments on health as % of total health expenditure

Source: WHO Health for All Database, 2013.

As can be seen in Figure 9, the Czech Republic and Turkey have followed opposite trends in terms of out-of-pocket spending on health care. From 29.8% level of spending in 1995, the private households out-of-pocket spending went down to 16.0%. In particular, a major drop coincides with the implementation of the mandatory general health insurance in 2008. The Czech Republic, on the other hand, increased out-of-pocket payments from 9.1% in 1995 to 14.7% in 2010, reaching the average level of EU-15 countries spending.

On the other hand, it is worth noting that the burden of out-of-pocket health expenditure in households is higher in the Czech Republic in 2009 (2.4% of household consumption) than in Turkey (1.5%) and some other OECD countries such as France (1.6%), the Netherlands (1.5%) and the United Kingdom (1.6%) (OECD, 2011b). Furthermore, out-of-pocket payments introduced in 2008-2009 had an impoverishing effect in poorer households; in particular, the households with pensioners were the most vulnerable (Krůtilová and Yaya, 2012).

The opposing trends in the two countries derive from their different starting points. Turkey moved from having the majority of its population without coverage in 1980s to implementing a mandatory general insurance model in 2008. With a significant decrease in the level of out-of-pocket payments and establishing universal coverage, Turkey moved towards improving the financial protection coming close to the average of EU-15. The Czech Republic started from a state-provided, universal coverage system to a social insurance model, which allowed for competition of health providers. As a result, out-of-pocket payments increased, particularly from 2005 onwards. While the system seems to have moved towards a less equitable position, it does not lag behind the EU-15 in financial protection.

5.2.2 Public health

Public health services and health promotion is an important element of a health system impacting the financing and sustainability of the system. The burden of diseases in OECD countries is more and more linked to lifestyle factors such as smoking, alcohol consumption, obesity, etc. (OECD, 2011). Therefore, promotion of a healthier lifestyle and prevention and early detection of diseases can relieve the health systems of major financial burdens.

As can be seen in Figure 10, spending on public health services increased from 2.7% to 5.6% of total health spending in Turkey between the years 1999 and 2011. The increase in the Czech Republic was smaller; it went up from 2.0% to 2.4%, which is close to 2.6% EU average.

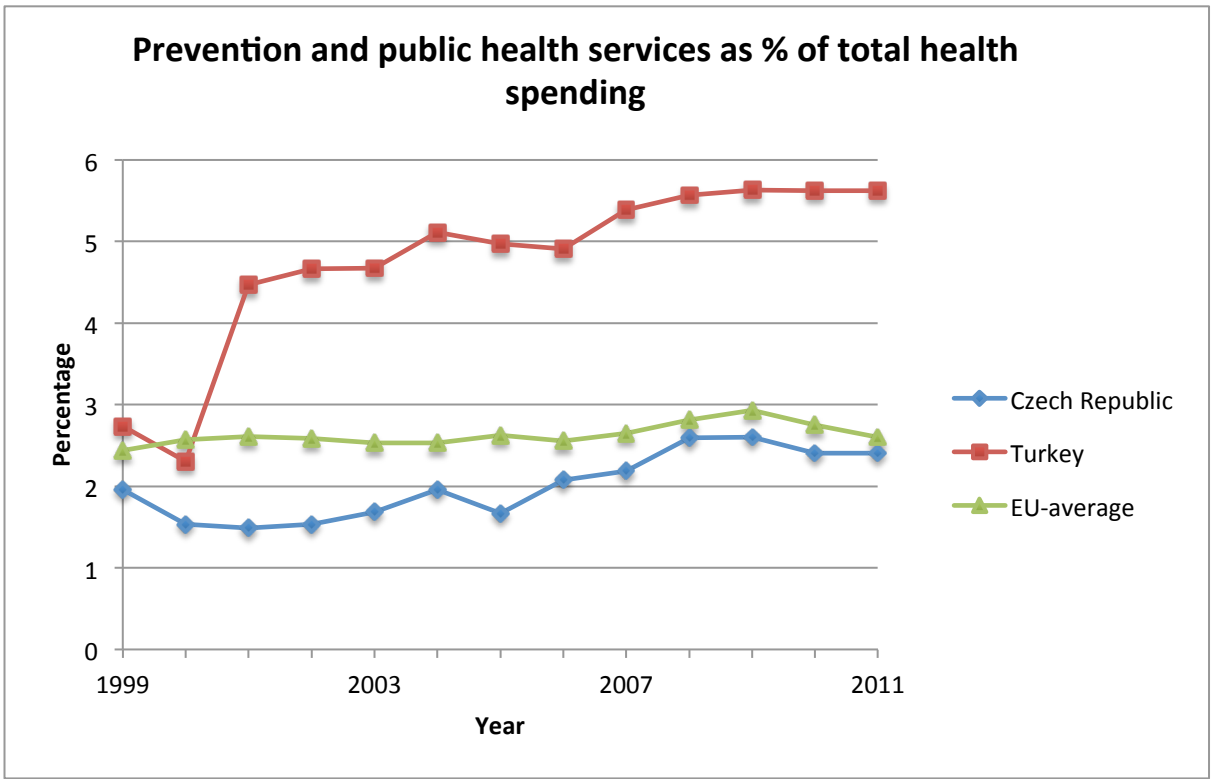

Figure 10: Prevention and public health services as % of total health spending

Source: WHO Health for All Database, 2013.

According to OECD Health data (2012a and 2012b), the Czech Republic has made some progress in reducing the percentage of adults who smoke daily from 26.1% in 1993 to 24.6% in 2008, however it is above the OECD average of 21.1%. Another health risk factor in the Czech Republic is alcohol consumption, with a consumption of 11.4 litres per adult in 2010, well above the OECD average of 9.5 litres. Obesity is also an increasing risk factor, which 21.0% of adult population suffered from in 2010, slightly below the average for the 15 OECD countries (22.3% in 2010). In Turkey, the infant mortality rate has fallen dramatically from 189 deaths per 1000 in 1960 to 10.1 in 2010, which is still above the OECD average of 4.3. Turkey achieved significant progress in reducing tobacco consumption decreasing from 47.4% in 1989 to 25.4% in 2010. In Turkey, the obesity rate among adults was 16.9% in 2010.

As can be seen in Figures 11 and 12, both countries improved their health status with regard to health indicators such as life expectancy and infant mortality rate. They have also been successful in reducing tobacco consumption. On the other hand, other life style factors such as obesity remain as health risks which can lead to increases in health problems and higher health care costs in the future. Given the percentage of resources allocated to public

health promotion and current focus on it reflected via health programs and public campaigns, public health has been given a higher priority in Turkey in the last decade than in the Czech Republic.

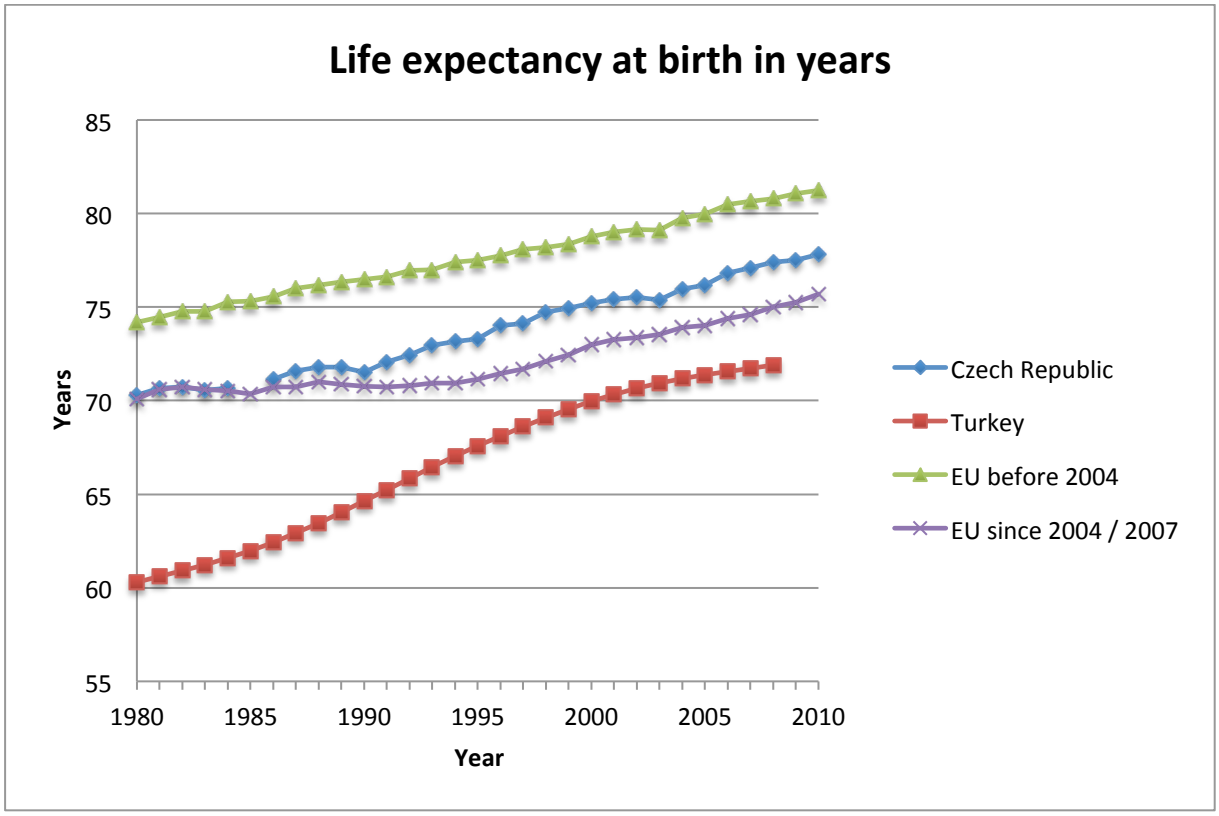

Figure 11: Life expectancy at birth in years

Source: WHO European Health for All Database, 2013.

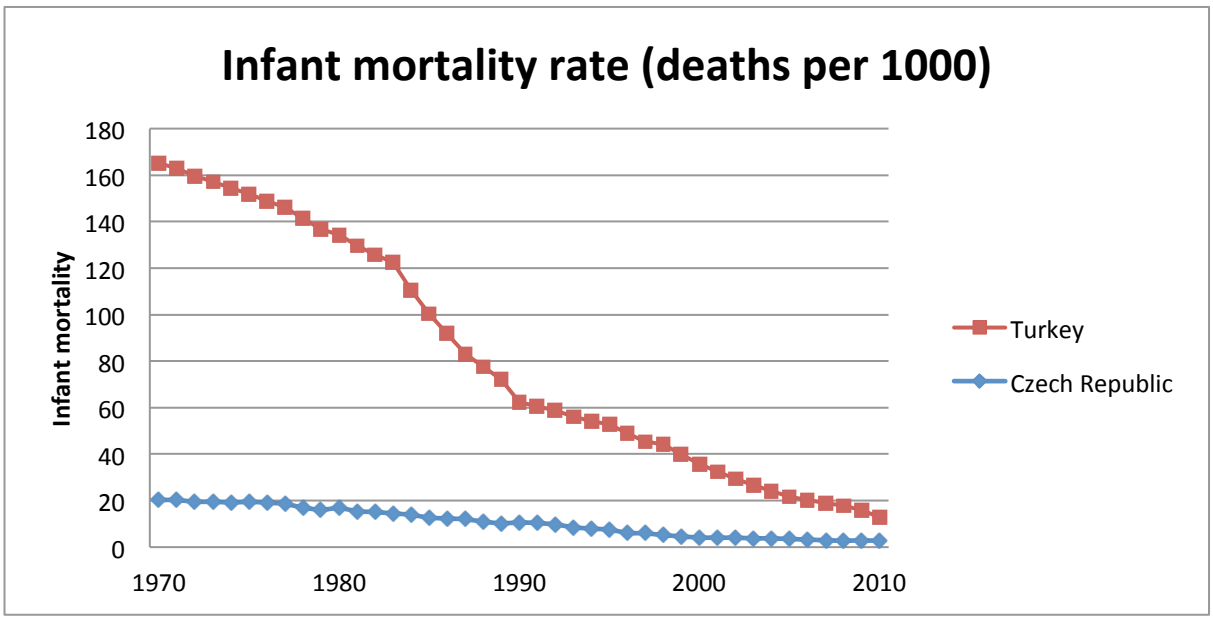

Figure 12: Infant mortality rate (deaths per 1000)

Source: OECD Health Data, 2013.

To what extent policies that were implemented in the two countries were able to support the achievement of primary goals of health policy can be a subject of further research. In terms of health financing, Turkey achieved considerable improvements in health care compared to its starting position by decreasing the level of out-of-pocket payments, establishing a mandatory universal insurance scheme and therefore increasing population coverage and increasing the level of health spending as a percentage of GDP. It has also allocated a significant share of resources to health promotion and prevention. However, in many indicators Turkey still lags behind OECD and EU-15 countries. And although the financial protection of individuals improved, there are concerns related to cost-sharing and collection of contributions from the vulnerable segments of the population.

In terms of health financing, the Czech Republic increased the level of out-of-pocket payments reaching the level of EU-15 average as a percentage of total health spending. It seems that both Turkey and the Czech Republic are converging to EU-15 levels in this indicator. With regard to the health gap, it can be said that the Czech Republic has not made significant progress since the revolution in catching up with OECD and EU-15 as demonstrated in major health indicators such as life expectancy. Obesity, tobacco and alcohol consumption become increasingly problematic; however, the public health and promotion does not seem to receive enough attention and investment in this function has been low over this period. This supports a general observation that public health was to some extent neglected in former communist countries following the introduction of social insurance system, which was a costly choice (Groenewegen, 2007).

6. Conclusion

"I dream of a republic independent, free and democratic, of a republic economically prosperous and yet socially just, in short, of a human republic which serves the individual and which therefore holds the hope that the individual will serve it in turn. Of a republic of well-rounded people, because without such it is impossible to solve any of our problems, human, economic, ecological, social or political."

Václav Havel, 1 January 1990

The well being of individuals within the society is both the source and result of economic and social development. Economic growth and social development depend on each other, for an increase in financial resources enables investments in the social development, such as health, education and social protection. In turn, such investments in society promote sustainable development and economic growth.

The focus of health policies has mostly been on cost-containment for several decades. Strategies were developed for dealing with cost-containment acting on the demand and supply side such as the introduction of cost-sharing, market mechanisms introducing competition between providers and performance-related payments. These policies were adopted by many countries whether their highest priorities were cost-containment or not.

Some of these measures undermined social solidarity by increasing health inequalities. The others raised concerns because of the ethical implications arising from the growing commercialization of health care. And although some of the measures have resulted in efficiency increases, they have not succeeded in containing overall costs. This long-standing focus on cost-containment also resulted in a lack of investments in health systems.

These policies spread around the world in the context of increasing globalization. Globalization has a cognitive dimension, which shapes patterns of thought, and as such health policy is shaped by a broader context of value systems, beliefs and interests. International agencies and organizations such as the WHO, World Bank, IMF, OECD and the EU play a significant role in disseminating ideas and influence the scope and nature of health policies by suggesting and drafting policies.

As this study aimed to demonstrate, the health care reforms in both Turkey and the Czech Republic were guided by international health reform experience and the expertise provided by international agencies. The global ideas on health were channeled through epistemic

communities, consultants, and a process of learning. Domestic policy contexts were particularly relevant in the diffusion of these policies: The ideological affinity of the governments and the existence of extraordinary circumstances leading to a break with the past like the major economic crisis in Turkey and the "shock therapy" transition in the Czech Republic which facilitated political changes were common pathways of diffusion in the two countries. The relative power of interest groups was also very significant in both countries, but in different ways: The representation of health professionals had a strong influence in the Czech health policy-making unlike in Turkey where medical association opposed the reforms and were not effectively included in the policy-making, but business association was an influential actor.

The policies that were adopted were originally derived from a struggle to improve cost containment in the Western health systems, and the common themes of reforms across Turkey, the Czech Republic and these countries suggest the problems were common everywhere. But this was not the case. The major issue in the Czech Republic was the health gap and in Turkey inequalities in health which naturally led to low health status.

The findings in this study suggest that health policy-making in local contexts is shaped by global patterns of thought. Countries have tendency to converge towards global norms as they become more and more integrated into a global order. This integration implies openness, which restricts countries in designing their own policies. Depending on the starting position of the country, such convergence can be seen as a gain or loss. For instance, in case of Turkey, a significant outcome of the reforms has been increased protection of patients from financial risk, universal coverage and an extensive standard benefits package. This was a result of efforts to raise the standards towards the average level of EU-15 countries. The Czech Republic also adopted a similar target, but for the Czech case it meant a lowering of standards from the perspective of patients' financial protection, since it started with a very low-level of out-of-pocket payments, which gradually increased towards EU-15 level. This could be seen as an evidence of openness driving countries to adopt a low common welfare denominator as discussed by Esping-Andersen (1996).

Economic interests took precedence over public health interests to raise health standards in the past decades. Public health seems to be located in "low politics". But in an interconnected world, the achievement of a balance between economic and social spheres becomes even more crucial for the sustainability of the global order. Globalization therefore brings also opportunities. The social construction of what is appropriate and legitimate can change over the next decades with an increasing awareness that health of the vulnerable

populations in the world is relevant for all populations. This can be achieved through strong governance and an inclusive policy debate in which a wide-range of informed actors, such as patients, take a more active role.

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