



The Political Economy of Health Reform: Turkey's Health Transformation Program, 2003-2012

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**THE POLITICAL ECONOMY OF HEALTH REFORM:
TURKEY'S HEALTH TRANSFORMATION
PROGRAM, 2003 - 2012**

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A Dissertation Submitted to the Faculty of
The Harvard T. H. Chan School of Public Health
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The Political Economy of Health Reform:
Turkey's Health Transformation Program, 2003-2012

Abstract

This dissertation explores the political economy of Turkey's large-scale health systems reform, known as the Health Transformation Program (HTP) (2003 – 2012). It does this by analyzing the role of institutions, physicians, and patients in the Ministry of Health's efforts to adopt and implement changes to the country's health financing, health workforce, and primary care systems.

In the first chapter, I present a qualitative case study that uses primary interview data to explain how Turkey adopted a universal and unified health coverage system between 2003 and 2008. By applying and then extending Immergut's institutional veto points theory, I show Minister of Health Akdağ (2002-2013) and his team of advisors used targeted strategies to overcome obstacles at critical veto points blocking adoption. This analysis fills an important gap in the literature on universal health coverage by providing a theory-based explanation for how a reform can be accomplished.

The second paper then looks at how Minister Akdağ and his team of advisors overcame opposition from an organized physician group, the Turkish Medical Association (TMA), to adopt legislation that banned physician dual practice. This analysis contributes to the literature on the role of physicians in health reform by presenting a case study where an organized physicians association was not able to act exert veto power to block policy adoption. Rather, I argue that Minister Akdağ and his team of advisors used a *divide and then conquer* political strategy, where they acted to exploit coordination problems among physicians by appealing to their individual interests and undermining the authority of TMA and its base of university physicians. These

dividing actions created a favorable political environment to ban dual practice and strengthen service delivery capacity.

The fourth chapter considers how the HTP affected patient satisfaction with the newly introduced family medicine centered primary health care systems. I take advantage of the staged-rolled out of family medicine centered primary health care at the provincial level to estimate its effect on patient satisfaction using provincially-representative patient exit survey data from 2010, 2011 and 2012. This study provides some of the first national level evidence that the introduction of family medicine centered primary health care can effectively improve patient satisfaction - a health system goal.

The final chapter summarizes the main results of Chapters 2, 3, and 4, discusses their limitations, and presents policy implications that can be derived from this research.

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Susan Powers Sparkes, 2015

CHAPTER 1: INTRODUCTION

Health system reform is an inherently political process (Roberts et al. 2003, Reich 1994). Reforms take place within political systems, are championed by political actors, and must be negotiated with multiple political stakeholders. Reforms inevitably require a redistribution of resources, which has important political implications. As a result, health reform can be confronted by a number of political and economic challenges that can affect its feasibility. At each stage of a reform, policymakers have to weigh these political economy considerations in their efforts to meet reform objectives (Fox and Reich 2013, Reich 2002).

Despite the importance of the political economy of the reform process, research on health systems reform tends to center on two distinct stages in the policy cycle: (1) the policy design and intended objectives of the reform and (2) the evaluation of the consequences and accomplishments of the reform. This focus may derive from the fact that progress towards reform objectives can generally be measured and assessed. Such evaluations are vital to understanding the relative success or failure of a health reform effort. However, they do not necessarily provide much insight on how policymakers secured adoption and ensured implementation of health reform proposals. The focus on success or failure rarely highlights or provides clarity on the “means” required to achieve a given “end” (Roberts et al. 2003). This focus also fails to show the critical political and economic challenges policymakers face in driving a reform effort, and the adaptations required to successfully overcome such challenges.

This dissertation is motivated by this gap in the literature on the political economy of health reform. It uses political economy analysis to explain how a large-scale health system reform was adopted and implemented. Political economy analysis explicitly examines the links between wealth and power, politics and economics, and national states and markets in a reform process

(Bump and Reich 2012). This dissertation uses this analytical approach, along with both qualitative and quantitative methods, to provide theory-based explanations of the political economy of health systems reform adoption and its consequences on public opinion in the case of Turkey.

This dissertation focuses specifically on how Turkey's Minister of Health, as head of the Ministry of Health (MoH), strategically managed institutional actors, physicians, and public opinion in the Health Transformation Program (HTP) that occurred between 2003 and 2012. Much of the analysis in this dissertation centers on Prof. Dr. Recep Akdağ, and his strategic actions as leader and champion of the HTP as Turkey's Minister of Health from November 2002 through January 2013. As Minister of Health for over 10 years, Akdağ and his team of advisors in the MoH oversaw all aspects of the design, adoption, and implementation of the HTP (Barış, Mollahaliloglu, and Aydın 2011, Atun et al. 2013, Johansen and Guisset 2012).

I examine the political economy of the HTP in three chapters. First, I analyze the adoption strategies used between 2003 and 2008 by Minister Akdağ and his team to overcome opposition at critical institutional veto points to a universal and unified health financing system. Second, I analyze how Minister Akdağ and his team put into place policies to strategically engage physicians and reduce their opposition, in advance of banning MoH physicians from concurrently practicing in both the public and private sectors ("dual practice"). Third, I assess whether the introduction of family medicine centered primary health care affected patient satisfaction.

This research is timely given that relatively few health systems reforms in low- and middle-income countries in recent years have fully achieved their policy objectives and reached the goal of universal health coverage (UHC) (Fox and Reich 2013). Turkey is held out as a prime example of a country that achieved UHC and expanded its primary health care system, while banning dual practice (Atun et al. 2013, Johansen and Guisset 2012). Despite attention to the achievements of

Turkey's health system reform, there has been little rigorous analysis of the adoption process of Turkey's reform and the effects of the reform on public opinion of the health system.

The remainder of this introduction provides: (1) background on the political and economic factors that facilitated adoption and implementation of the HTP, (2) a brief overview of the health system reform in Turkey, and (3) the goals of this dissertation and briefly summarizes the three chapters to follow.

Background on political economy of health reform in Turkey

In the November 2002, the Adalet ve Kalkınma Partisi (AK Party) won a super-majority in the Turkish Parliament. The elections that brought the AK Party to power grew out of growing public dissatisfaction with coalition governments following a series of high profile corruption scandals and economic crises (Heper 2003). Voters expressed their readiness for change by evicting all political parties that had previously been represented in Parliament – none reached the 10 percent threshold required for parliamentary representation – and handing the AK Party the country's first outright parliamentary majority in more than 40 years with 34.3 percent of the popular vote (Heper 2003). Given the highly centralized nature of the Turkish state, this parliamentary victory translated into control of many public sector actions at the local level (Tatar et al. 2011).

The AK Party had just been formed in 2001. While the AK Party avoided religious issues in its campaign, it was widely recognized as an offshoot of the Islamist parties that were banned by the Constitutional Courts for violations of the secular principles in the Turkish Constitution (Kanra 2005). The party's platform was centered on opposition to inequalities present in the country (Barış, Mollahaliloglu, and Aydın 2011). The AK Party's electoral base was rooted in the more rural and religiously conservative areas of the country, but it also had the support of some

business leaders who were eager to address the economic problems of previous governments (Özbudun 2006).

Opposition to the AK Party came largely from the more affluent, well-educated sections of Turkey's population. Specifically, white collar workers, retired army officers, government bureaucrats, academics, college students, left-leaning intellectuals, entrepreneurs, and the labor unions. These groups feared that Turkey's long history of secularism, which dated to the founding of the Turkish Republic in 1923 by Mustafa Kemal Atatürk, was under threat by the AK Party Government (Aybars and Tsarouhas 2010). As a result of these political and economic considerations, the AK Party sought to quickly deliver on its reform promises to both maintain the support of its electoral base and assuage public concerns about the legitimacy of opposition groups' messages.

Health Reform and the Health Transformation Program

Health reform was a central component of the AK Party platform, with the goal of reducing disparities in health outcomes and access to health services, and improving the overall health of the Turkish population. These reform priorities were not novel in Turkey. The same initiatives had been actively discussed and debated at all levels of government for over 15 years but had not resulted in significant changes to the health system (Atun et al. 2013, Tatar et al. 2011, Bump and Sparkes 2014).

In 2002, Turkey's health financing system was highly fragmented. Large segments of the population had no coverage and those that did experienced significant disparities between benefit packages and discrepancies in access to services (OECD, World Health Organization, and World Bank 2008). Alongside the fractured financing system was a low-quality, under-staffed public care delivery system that was inaccessible to large portions of the population. (OECD, World Health

Organization, and World Bank 2008). Turkey's inadequate health facility infrastructure was compounded by an overall shortage of health workers (Vujicic, Sparkes, and Mollahaliloglu 2009, Savas, Karahan, and Saka 2002).

The inefficiency, fragmentation and inequity of the health system resulted in low citizen satisfaction with health services. In 2003, only 39.5 percent of the population indicated that they were satisfied with the quality of care, as compared to 48 percent in Greece, 55.3 percent in Spain, and 84.1 percent in France (OECD, World Health Organization, and World Bank 2008, Bleich, Özaltin, and Murray 2009). In addition to being dissatisfied, Turkish citizens also experienced relatively poor health outcomes. The infant mortality rate (24.4 deaths per 1,000 live births in 2003) and the maternal mortality ratio (33 per 100,000 live births in 2000) were some of the highest among middle-income countries at the start of the HTP (Turkey Ministry of Health 2011, World Bank 2013b). In 2003, only 58 percent of children 12–23 months old were fully immunized (Turkey Ministry of Health 2011, World Bank 2012a). Health status was particularly low in rural and poor areas of the country. In terms of financial protection, out-of-pocket (OOP) expenditures represented approximately 20 percent of total health expenditures in 2003, well below global averages for comparable countries. Despite this relatively low rate, the impoverishing effect of these OOP expenditures was substantial – with an additional 3.8 percent (2.6 million people) of the population falling below the \$2 a day poverty line as a result of paying for healthcare (World Bank 2012a).

The AK Party, almost immediately after taking power, addressed potential reforms in the health sector. In December 2003 the MoH published “Transformation in Health,” which laid out guidelines for the HTP reform (Republic of Turkey Ministry of Health 2003). This report discussed the contents of the reform, how the reform would be implemented, and its goals and targets. On

the financing side, the HTP planned to unify the various financing and social security schemes operating in the country under a single health insurance scheme that provided comprehensive coverage for all Turkish citizens. With respect to service delivery, it sought to expand and improve the quality of the primary health care system, increase productivity, and provide for a united and more autonomous public hospital system.

During the period of the HTP, the AK Party's efforts led to broad reforms, and achieved many of the originally stated reform objectives. By 2012, 98 percent of the population was covered by the unified General Health Insurance Scheme with a single benefit package and rules of access (see Chapter 2 for more details) (Akdağ 2011). Expansions in coverage and service delivery had measurable effects on input, process, and outcome indicators. Regional differences in the availability of primary care physicians decreased and the share of the population that chose to utilize outpatient services increased from 38 percent in 2002 to 51 percent in 2010 (Akdağ 2011, World Bank 2013a). The HTP's focus on improving access to and use of maternal care led to substantial increases in antenatal visits and the proportion of birth attended by skilled staff (World Bank 2012b). These improved utilization rates contributed to a 40 percent reduction in maternal mortality between 2000 and 2010, and a more than 50 percent reduction in both infant and under-five mortality between 2003 and 2012 (see Table 1.1) (Turkey Ministry of Health 2012, World Bank 2012b, Atun et al. 2013).

Table 1.1: Selected health system and health status statistics, Turkey

	2003	2012
Total health spending per capita, PPP (constant 2005 international \$)	450	1,144
Health expenditure, public (% of total health expenditure)	72	74
Out-of-pocket spending as share of total health spending (%)	18.5	16.8
Primary care visits per capita	0.9	2.8 (2009)
Share of pregnant women receiving at least 4 antenatal visits (%)	53.9	73.7 (2008)
Proportion of births attended by skilled staff (%)	83	95 (2008)
Share of fully immunized children (%)*	53	74 (2008)
Maternal mortality ratio (modeled estimate, per 100,000 live births)	33 (2000)	20 (2010)
Mortality rate, infant (per 1,000 live births)	24.1	12.1
Mortality rate, under-5 (per 1,000 live births)	28.8	14.2
Share of population satisfied with health system (%)	39.5	74.8

Source: World Bank, World Development Indicators 2014; Turkey Life Satisfaction Survey, 2003-2012; World Bank 2013, Turkey Demographic and Health Surveys 2003 and 2008,

Data are for 2003 and 2012 unless indicated in parentheses.

*Includes children between 12 months old and 24 months of age that have received BCG; diphtheria– tetanus– pertussis 1, 2, and 3; polio 1, 2, and 3; and measles

In summary, AK Party leaders took advantage of economic and political conditions that facilitated reform to push through an ambitious health reform agenda. They focused on delivering promised results to demonstrate a deep commitment to improved equity in Turkey, and thus contributed to ensuring a longer tenure of the AK Party as Turkey’s ruling party. While the political, economic, and health system conditions at the start of the HTP created an impetus for reform, careful analysis is needed to understand how the AK Party and MoH leaders adopted and implemented their health reform plans to achieve their objectives.

Goals and structure of dissertation

In this dissertation, I argue that in any significant health reform, policymakers will confront the interests of institutional actors, physician groups, and patients in the process of reform.

Therefore, understanding how Turkish reform leaders engaged these three interests to ultimately adopt and implement their reform agenda provides an important contribution to the literature on health systems reform and the HTP. Through this analysis, I also inform policymakers in other countries on the strategic approach to reform used by Turkish leaders that could hold potentially important lessons for reform processes in other contexts.

I accomplish these objectives by analyzing the role of institutions, physicians, and patients in the MoH's efforts to adopt and implement changes to the country's health financing, health workforce, and primary care systems – three core functions of any health system. This dissertation provides theory-based, structured explanations of how the leaders of the Turkish reform, specifically Minister of Health Akdağ and his team of advisors, adopted certain core elements of the HTP. It also shows how changes to the primary care system increased satisfaction amongst its users and built public support for the HTP agenda (while also generating consequences for health status). I use qualitative and quantitative methods to address the following research questions in the following three chapters:

- Chapter 2: How did Minister of Health Akdağ overcome opposition at critical institutional veto points to adopt a universal and unified health financing system in Turkey between 2003 and 2008?
- Chapter 3: How, in the face of strong opposition from the Turkish Medical Association, did Minister Health Akdağ accomplish his goal of banning dual practice for Ministry of Health physicians between 2003 and 2010?
- Chapter 4: What was the impact of the introduction of family medicine centered primary health care (i.e. Family Medicine System) on patient satisfaction with primary health care services?

Chapters 2 and 3 of this dissertation look at issues related to the adoption of the HTP. Chapter 2 analyzes the adoption process of Turkey's universal and unified health coverage system. This research is situated within the broader, global policy dialogue that stresses the importance of achieving UHC in low- and middle-income countries as a critical health system reform objective (Latko et al. 2012, Sachs 2012, United Nations General Assembly 2012, Vega 2013, World Health Organization 2010, 2005). Despite this broadly acknowledged view on the importance of UHC, Turkey remains an outlier in its ability to achieve both a universal and unified system of coverage. This paper analyzes the policy adoption process in Turkey to explain how Minister of Health Akdağ achieved the goals of his UHC reform agenda. It is motivated in large part by the question of why the HTP achieved its financing objectives, whereas other reforms in Turkey before had failed. Using qualitative interview data and an extensive literature review, I apply Immergut's (1992) theory of institutional veto points to first identify formal institutional obstacles (veto points) to the adoption of a universal and unified health coverage system in Turkey. Second, I analyze the political strategies that Minister of Health Akdağ used to overcome this opposition at the institutional veto points. By focusing on Minister Akdağ's strategic actions, this research contributes to theories of policy adoption and provides a typology of adoption strategies that should be explored in other reform contexts in Turkey and elsewhere.

Chapter 3 examines how a ban on dual practice for public sector physicians was adopted between 2003 and 2010. There is a common perception that physicians, and in particular the medical associations that represent them, can act as veto players in a reform by blocking any policy that they oppose, especially related to physician payment (Marmor and Thomas 1972, Immergut 1992, Eckstein 1960). However, the dual practice ban in Turkey was put into place despite the strong opposition of the Turkish Medical Association. To do that, the MoH had to change how the

majority of public sector physicians in Turkey practiced medicine. To explore the process for achieving this policy change, Chapter 3 uses qualitative interview data to analyze the policies that the MoH adopted in advance of putting forward legislation to formally ban dual practice. The analysis examines how Minister Akdağ used “divide and conquer” strategies to exploit coordination problems amongst groups of physicians to reduce opposition from individual physicians and diminish the role of the Turkish Medical Association as a veto player opposed to reform (Posner, Spier, and Vermeule 2010). I go on to discuss the consequences of this strategic approach on the MoH’s ability to achieve a complete ban on dual practice and for the health system more broadly.

Chapter 4 evaluates the effect of HTP implementation on the perceptions of the health system by its users. Along with achieving UHC, reforming Turkey’s primary health care system was a central focus of the HTP policy agenda (Republic of Turkey Ministry of Health 2003, Akdağ 2011, 2009, World Bank 2013a). The introduction of the Family Medicine System between 2005 and 2011 was the policy vehicle used to accomplish this objective. This paper uses a fixed effect approach to analyze data from the Turkish Patient Satisfaction with Health Services Survey 2010, 2011 and 2012 to compare changes in satisfaction before and after the introduction of the Family Medicine System. Two approaches are taken to identify outcome variables to reach robust and interpretable results. I discuss the importance of these findings both with respect to the success of the Family Medicine System, as well as for policymakers seeking to alter health seeking behavior and build political capital for future elections.

Chapter 5 concludes the dissertation with a summary of the results of the three studies and their limitations, a discussion of policy implications of the findings, and recommendations for future research.

Authorship and collaboration

The research grew out of a World Bank project with the Ministry of Health of the Republic of Turkey on the broader political economy of the design and adoption of the HTP. As such, initial qualitative interviews related to Chapters 2 and 3 took place as part of this World Bank project and were done in collaboration with Professor Jesse B. Bump. I am the lead author on all three chapters, developed the analytical frameworks, and conducted all related analyses. I also wrote all initial drafts of each paper and then received valuable edits, comments, and feedback from co-authors. Co-authors for Chapter 2 are Professor Jesse B. Bump and Professor Michael Reich. Co-authors for Chapter 3 are Professor Rifat Atun and Professor Michael Reich. Co-authors for Chapter 4 are Rifat Atun and Till Bärnighausen.

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CHAPTER 2: STRATEGIES TO ADOPT A UNIVERSAL AND UNIFIED HEALTH COVERAGE SYSTEM IN TURKEY: HOW INSTITUTIONAL VETO POINTS SHAPED THE PROCESS

Introduction

Of the low- and middle-income countries that have introduced reforms to move towards universal health coverage (UHC) in recent years, Turkey is one of the few to realize both a universal and unified system of coverage. Major reforms in Mexico and Thailand, for instance, have fallen short of placing all their citizens under a single insurance coverage scheme with a single benefits package (Lakin 2010, Pannarunothai, Patmasiriwat, and Srithamrongsawat 2004). These countries still have multiple systems of coverage with more restricted benefits for lower-income groups.

In 2003, Turkey's newly elected Adalet ve Kalkınma Partisi (AK Party) Government promised to improve public health, expand health insurance to all citizens, and guarantee provision of and access to high-quality health services (Atun et al. 2013). To accomplish these goals, the incoming Minister of Health Recep Akdağ introduced a series of reforms under the Ministry of Health's (MoH's) Health Transformation Program (HTP). A central component to the HTP was to insure Turkish citizens under a publicly-run, single-payer health coverage scheme that provided equal access to all health facilities covered under the scheme (Republic of Turkey Ministry of Health 2003).

On at least nine separate occasions prior to 2003, Turkey had attempted to establish a national health insurance system and achieve UHC (OECD, World Health Organization, and World Bank 2008, Akdağ 2009, Yıldırım and Yıldırım 2011, Atun et al. 2013). These prior

attempts were blocked by legislative gridlock in the Parliament, opposition to new legislation by the Constitutional Court, and a rapid turnover of ministers of health that created instability in the policy agenda (OECD, World Health Organization, and World Bank 2008). The national elections in 2003 gave the AK Party a parliamentary super majority, which eliminated the problem of legislative gridlock. However, Minister Akdağ's proposal to create a universal and unified health financing system still confronted opposition from people within the government bureaucracy, executive leadership, and the judicial branch. Part of the resistance to AK Party initiatives came from secularists, who opposed the Islamist orientation of the AK Party platform (Atacan 2005).

In this paper, we explain how Minister Akdağ and his reform team overcame opposition to adopt a universal and unified health financing system in Turkey between 2003 and 2008. Our references to Minister Akdağ below include his team of advisors that worked closely with him in designing, adopting, and implementing the HTP. This team was comprised of technical experts, many of whom had worked on previous attempts to establish a national health insurance system (I-32, I-18, I-11). Importantly, Akdağ was Minister of Health from November 2002 through January 2013, which provided consistent leadership for the AK Party's health reform agenda over the period studied by this paper and beyond.

Immergut's (1992) institutional veto points theory is the starting place for our analysis. We use this theory to identify the institutional veto points, which we defined as formal institutions with the ability to block the adoption of either administrative or legislative policy proposals to reform Turkey's health system. Through case study analysis, we then extend this theory to show how Minister Akdağ designed strategies that addressed and overcame opposition at the veto points, resulting in the adoption of a universal and unified health financing system in Turkey—a major reform accomplishment. This paper demonstrates the potential importance of institutional veto

points in structuring the policy adoption process. It also shows that veto points are not binding constraints to reform; strategic action by policymakers can overcome them in some circumstances.

The paper is organized as follows: Section 2 presents the conceptual framework used to motivate and structure the analysis. Section 3 provides a brief review of relevant literature on institutional veto points theory and the process of health reform in Turkey. Section 4 describes the data and methods used. Section 5 applies the institutional veto points theory to the adoption of health reform policies in Turkey between 2003 and 2008. Section 6 uses this framework to analyze institutional opposition to the adoption of a universal and unified health financing system in Turkey between 2003 and 2008, and the strategies used to overcome this opposition. Section 7 discusses the implications and lessons that emerge from this analysis and the limitations of this analytical approach. Section 8 provides a brief conclusion.

Conceptual framework

The conceptual framework for this analysis is derived from the approach Ellen Immergut used to answer the question, “Why do countries with similar levels of development have different health care systems?” (Immergut 1992, 2). Through her comparative research on the Swedish, Swiss, and French health and political systems, she showed that interest groups, political actors, and policy proposals did not differ significantly across the three countries over the course of the 20th century. But differences in health systems could be explained by differences in incentives, opportunities, and constraints for political influence resulting from the institutions involved in making policy decisions. The combination of these factors created sites of contestation that she identified as her primary explanatory variable and termed institutional veto points. She defined these as the “political arenas in which government proposals may be blocked” (Immergut and Abou-Chadi 2010, 8).

We use Immergut's theory of institutional veto points to structure our analysis of Turkey's health reform and show how institutional veto points affected the policy adoption process. Our analysis then proposes an extension of this theory to show how institutional veto points can be overcome through the skillful use of political strategies. We find that Minister Akdağ used strategies to avoid specific obstacles, delay while facilitating institutional change, persuade and compromise, and overpower opponents, to deal with opposition at the institutional veto points. This proposed extension of the institutional veto points theory should be further explored in other reform contexts.

Relevant literature in political science and health

Institutional veto points and policy reform

Past studies using institutional veto points theory have analyzed how differences in institutional arrangements explain differences in policy outcomes across countries over time (Immergut 1992, Rothstein 1995). Immergut's (1992) comparison of Sweden, France and Switzerland shows how variations in institutional veto points (rather than veto groups) explain differences in the adoption of national health insurance systems across the three countries. A similar approach was taken to explain economic reform in transition economies, pension reform in Europe, the implementation of European Union directives, and investment decisions in developing countries (Hellman 1998, Ganghof 2003, Bonoli 2000, MacIntyre 2001, Haverland 2000).

Our analysis of Turkey's health reform adds to the literature on institutional veto points by providing a new case study to show the importance of institutional veto points in determining the outcome of policy processes, especially whether and how a specific reform is adopted. However, rather than focusing on how veto points structure the actions and influence of interest groups, we

examine how institutional veto points shaped the strategies used in minister-led reform (Gershberg 1999). Our approach is an important contribution to the literature because it shows how a policymaker can strategically shape the process for policy adoption to overcome institutional veto points and move reform forward. We show that opposition at institutional veto points alone does not determine the outcome of reform efforts.

Health Reform in Turkey

Relatively few studies have examined how the Minister of Health, and more broadly the Government of Turkey, came to adopt the HTP. Most studies have focused on the effects of the reform on improving access to healthcare or health outcomes. Those studies that mention the process of reform do not provide detailed analysis, although they do acknowledge that political, historical, and economic factors were important to the reform. For example, Atun et al. (2013) present a list of five contributing factors (from leadership and political commitment to a flexible implementation plan) that facilitated the adoption and implementation of the HTP (Atun et al. 2013). A similar approach is taken in other studies that discuss the adoption of the HTP (Yıldırım and Yıldırım 2011, Barış, Mollahaliloglu, and Aydın 2011, Johansen and Guisset May 2012). These studies are not grounded in a theoretical framework of politics and do not undertake a detailed analysis of the reform process. These limitations make it hard to reach robust conclusions about effective policy adoption strategies in Turkey and their implications for health reforms in other settings.

In this paper we use institutional veto points theory to structure our examination of the adoption processes of Turkey's health reform, to explain the obstacles to reform, and how proponents overcame them. This analysis contributes to the literature on Turkey's health reform by providing a theory-based explanation of how the government achieved the adoption of its

reform proposal and by placing this major achievement within the political science literature on institutional obstacles to policy reform.

Data

Qualitative data for this analysis were collected through semi-structured interviews and documents collected from the published and grey literature on Turkey's health reform and the political economy of the HTP.

Interviews

The interview process was multi-staged. First, initial interviews took place in March and April 2013 in Ankara and Istanbul, Turkey. These stakeholder interviews were conducted by Bump and Sparkes as part of an investigation of the general political economy of the HTP (Bump and Sparkes 2014). We used a purposeful sampling approach to identify interviewees by constructing a preliminary list of stakeholders prior to arriving in Turkey based on a literature review of health reform in Turkey and other countries. To help ensure consistency and completeness, we wrote a semi-structured interview guide. Second, as part of this same project, in May 2013 Bump and Sparkes interviewed current and former World Bank officials who had been directly involved with health reform in Turkey before and during the HTP.

From these initial interviews, we developed a hypothesis about the importance of institutional veto points to the adoption of a universal and unified health financing system in Turkey. Sparkes then conducted two subsequent rounds of interviews to ask targeted questions on this hypothesis. In the third round of interviews, Sparkes collected extensive qualitative interview data through ten one-on-one and group discussions with former Minister Akdağ in the fall of 2013, after he had left office. Sparkes conducted the fourth round of semi-structured interviews in January 2014 in Ankara and Istanbul to ask key informants specific questions related to the

adoption strategies used by Minister Akdağ and his team relative to institutional veto points. Maximum variation sampling was used to ensure that a wide range of perspectives on the reform process were taken into account (Hardon, Hodgkin, and Fresle 2004). Interviewees included representatives from government, professional associations, academia, health professionals, and the World Bank, and were arranged with assistance from colleagues at the MoH, and also independently based on our own contacts in Turkey. The distribution of interviewees across different stakeholder groups is shown in Table 2.1.

Table 2.1: Interviewee Groups

Stakeholder Group	Number of Interviewees
Government	16
Professional Associations	5
Academia	4
Health Professionals	6
World Bank	5

Source: Authors

Interviews were conducted in English, in a mix of Turkish and English, or in Turkish with professional interpretation, according to circumstances. Each interviewee was informed of the purpose of the study, of our intention to take detailed notes of each interview, and of our process for handling interview data. We requested permission to take notes and to report quotes attributed to a general affiliation. IRB approval was granted for this study (IRB13-1294) and deemed exempt by Harvard School of Public Health’s Office of Human Research Administration. Interviews are cited in this paper according to the number assigned to the interviewee.

Documents

We collected documents in the grey and published literature on Turkey’s health reform to develop our ideas and gather information, and help reduce possible bias introduced through stakeholder interviews (Maxwell 2013). Keywords for collecting materials included health reform in Turkey, the HTP (in abbreviation and full name), political economy of the AK Party, and institutional veto points. We reviewed research articles, government documents, and newspapers

articles. Google Translate was used for all sources written in Turkish. Although this is not a precise method of translation, we argue that it was sufficient to confirm or counter information collected through interviews. Translated Turkish documents were only used to triangulate data collected from other sources and were not used as a primary source because of our concerns about the limitations of machine translation.

Analysis

After the first phase of interviews, Bump and Sparkes conducted a stakeholder analysis, which is a structured method for assessing the “behavior, intentions, interrelations, agendas, interests, and the influence or resources” of relevant actors concerning a particular policy or issue (Brugha and Varvasovszky 2000). This examination of stakeholders was the first analytical step. By assessing stakeholders, we were able to map supporters, opponents, and strategies for increasing the likelihood of policy adoption success (Reich 1995, Varvasovszky and Brugha 2000, Roberts et al. 2008).

The second step in our analysis was to use Immergut’s theory to identify the formal institutional veto points that affected the Turkish health policy adoption process between 2003 and 2008. We defined institutional veto points as formal institutions with the ability to block either administrative or legislative policy proposals, following Immergut’s conclusion that “political decisions require agreement at several points along a chain of decisions made in different arenas” (Immergut 1990, 396). Institutional veto points were identified through detailed interview questions with relevant stakeholders, as well as through the in-depth literature review. The list of institutional veto points involved in health policy reform in Turkey was developed based on the first three rounds of interviews and the literature review. To confirm accuracy, the veto points were

presented to interviewees in the fourth round who had been directly involved in the adoption of the HTP.

In the third step of our analysis, we conducted a case study of the role of these institutional veto points in the adoption of a universal and unified health financing system between 2003 and 2008 in Turkey. We selected this case because the achievement of a single-payer social security scheme that covered all Turkish citizens under a single benefit package was characterized as critical to the achievement of the HTP policy objectives in policy documents setting out the reform plans in December 2003, as well as by all interviewees involved in the reform (Akdağ 2011, Republic of Turkey Ministry of Health 2003, World Bank 2003). To conduct this case study, we collected data from interviewees, published sources and government documents, on the key policies that expanded and unified the financing system. We asked interviewees about the specific policy adoption strategies used to promote these policies based on the relevant institutional actors involved, with a focus on institutional veto points.

Outcome variable: The outcome variable for this analysis is the adoption of a universal and unified health financing system in Turkey. This outcome variable is defined in two ways based on the type of legislative or administrative instrument involved. For primary laws, adoption is defined as the full passage into legislation and the publication of the law in the Official Gazette. With regard to secondary level regulations and tertiary level ministerial directives and circulars, adoption is defined as implementation because the Minister of Health and/or the Council of Ministers could implement these measures without further hurdles.

Explanatory variables: There were three explanatory variables that affected whether the new financing system was adopted: (1) the institutional veto points that could block adoption; (2) the political actors at each institutional veto point; and (3) the reform strategies used by Minister

Akdağ to address opposition at each veto point. We identified these variables based on Immergut's institutional veto points theory and through initial interviews that highlighted the importance of Akdağ's strategies to overcome opposition at each veto point.

All interviews were transcribed into Microsoft Word. The data were then coded to indicate whether they provided information on relevant institutional veto points, the political actors at each institutional veto point, or the strategies used by Minister Akdağ to adopt his policies. This coding process allowed us to develop important themes about the role of institutional veto points in the adoption of reform, how those veto points shaped reform adoption strategies, and how Minister Akdağ's strategies overcame opposition at the veto points.

Institutional veto points to health policy reform in Turkey, 2003–2008

In this section, we identify and examine the institutional veto points in Turkey that could have blocked the health reform efforts of the Minister of Health and his team. Our analysis of institutional veto points expands on Immergut's focus on referenda, constitutional courts, and legislative bodies, by also examining the role of lower level government institutions and administrative instruments as part of the reform process.

Turkey had three levels of authority involved in adopting different types of administrative and legislative instruments under the HTP. These three categories were described to us by ministerial attorneys and policymakers in Turkey.

Primary authority was required to create new institutions and make large changes to the overall government budget through legislation. Institutions holding primary authority to block legislation included the MoH, Council of Ministers, Prime Minister, President, and Constitutional Court.

Secondary authority was required to change the MoH budget and make policy changes that impacted multiple ministries through Regulations. Institutions holding secondary authority included the MoH, Council of Ministers, Prime Minister and Council of State.

Tertiary authority was held by MoH and could be used to make changes to existing ministerial programs and to implement primary legislation through Ministerial Directives and Circulars.

In total, we identified seven institutional veto points that had the ability to block the adoption of legislative and administrative instruments for health reform in Turkey. Table 2.2 presents these seven institutional veto points and describes their potential capacity to block adoption according to level of authority.

Table 2.2: Potential Institutional Veto Points According to Level of Authority in Turkish Health Reform Adoption Process

Institutional Veto Point	Primary Laws	Secondary Regulations	Tertiary Ministerial Directives and Circulars
1. Ministry of Health	Capacity to block changes to MoH policies or programs by refusing to put forward laws for further approval.	Capacity to block any proposed changes to MoH policies or programs by refusing to put forward regulations for approval or through representation in Council of Ministries.	Capacity to block because any changes to ministerial programs or policies had to be put forward and approved by the Minister of Health
2. Council of Ministers ¹	Ministries directly affected by potential reform had the capacity to block adoption through their representation in the Council of Ministers.	Ministries directly affected by potential reform had the capacity to block adoption through their representation in the Council of Minister.	
3. Prime Minister	As head of Government, the PM had the capacity to unilaterally block adoption by refusing to put forward legislation for parliamentary approval.	As head of Government, the PM had the capacity to unilaterally block adoption if disagreed with policy.	
4. Council of State		The Council of State is the highest administrative court in Turkey and had the capacity to block adoption due to its role in adjudicating disputes over administrative instruments and any disputes between ministerial entities.	
5. Parliament	Capacity to block if a majority of the 550 members of the Parliament voted against proposed legislation.		
6. Office of the President	Capacity to block by referring legislation passed by Parliament to the Constitutional Court based on potential violation of the Constitution, or by referring legislation back to Parliament.		
7. Constitutional Court	Capacity to block by ruling against constitutionality of legislation and thus block adoption. Its decisions were binding.		

Source: Authors

¹ As heads of their respective ministries, each Minister was responsible for the general policy of the government and for matters within the jurisdiction of his or her own ministry (Turkey Directorate General of Press and Information 2006).

We use this list of seven potential institutional veto points presented in Table 2.2 to identify those that actually constituted serious obstacles to the adoption of the universal and unified health financing system in Turkey between 2003 and 2008. We discuss these actual institutional veto points in the next section.

Case study: adopting a universal and unified health financing system

Pre-reform system

In 2003, when the AK Party came into office, approximately half of the population was insured by one of the three social security institutions: (1) the Sosyal Sigortalar Kurumu (SSK) for blue and white collar workers in the government and private sectors (33 percent of the population); (2) the Bağ-Kur for artisans and the self-employed (12 percent of the population); and (3) the Emekli Sandığı for retired government employees (5 percent of the population) (OECD, World Health Organization, and World Bank 2008). The SSK and Bağ-Kur each had separate management structures within the MoLSS, and the Emekli Sandığı was managed by the Ministry of Finance (Yıldırım and Yıldırım 2011). The three social security institutions were funded through a combination of payroll taxes, employer contributions, and general government tax revenues. Each institution had its own benefit package and payment system, which led to differences in access, services covered, and co-payment contributions (Yıldırım and Yıldırım 2011).

Unemployed individuals and informal sector workers were left without insurance coverage, unless they qualified for the MoH's Green Card Program (Erus and Aktakke 2011). The Green Card Program was established in 1993 as a special non-contributory low-income insurance scheme that reimbursed low-income households for all inpatient expenses incurred in public facilities (Karadeniz 2012). Outpatient services were not covered. As of 2002, approximately 9

percent of the population was eligible for coverage under the Green Card Program; however, due to bureaucratic, and sometimes corrupt, enrollment procedures, only approximately 3.7 percent of the population was enrolled (Aran and Hentschel 2012, I-25, I-17) .

Four funding mechanisms covered the Green Card and other aspects of the public health system. The MoH budget covered its own direct expenses and MoH hospitals, as well as the Green Card Program. The Council of Higher Education funded university hospitals, the Ministry of Defense funded its own system, and the Ministry of Finance directly paid the healthcare costs for current civil servants (about 7 percent of the population) (OECD, World Health Organization, and World Bank 2008).

HTP's health financing reform proposal and policy outcome

In 2003, the new Minister of Health sought to create a single-payer health financing system with a common benefits package for all Turkish citizens and a clear purchaser-provider split (Republic of Turkey Ministry of Health 2003). This goal required the unification of the numerous social security and health financing schemes, which were divided between the MoH and MoLSS. The MoH took a staged approach to the reform process, so as to maintain control over as much of the policy agenda as possible (I-17, I-5). At the beginning, Green Card holders were the focus of the MoH efforts. In 2004, outpatient care was added as a benefit for Green Card holders, and in 2005, benefits were further expanded to include outpatient prescriptions. The expanded benefits plus efforts to streamline the enrollment process produced an increase in Green Card holders from 2.5 million in 2003 to 9.1 million in 2011 (Akdağ 2012, OECD, World Health Organization, and World Bank 2008). Next, between 2005 and 2007 benefits were gradually upgraded and harmonized across the three social security schemes of SSK, Bağ-Kur, and Emekli Sandığı (OECD, World Health Organization, and World Bank 2008).

In 2006, two separate laws, Law 5502 and Law 5510, were presented in Parliament that if passed together would have fully unified all social security and health financing schemes and establish the Social Security Institution (SSI) as a single-payer organization (OECD, World Health Organization, and World Bank 2008). These laws primarily involved structural changes to the administration of health financing because the unification of benefits and the expansion of coverage had already occurred. However, only Law 5502 was fully adopted in 2006. This law provided the legal framework to unify the three social security schemes under the SSI. Law 5510, the Law on Social Security and Universal Health Insurance (SSUHI Law), was passed by Parliament but was referred by the President to the Constitutional Court, where it was ruled unconstitutional. The SSUHI Law sought to integrate the direct health financing schemes into the SSI as a compliment to Law 5502's integration of the three social security schemes. Groups affected by the proposed law included active civil servants and Green Card beneficiaries. Members of Parliament, prisoners, conscripts and those enrolled under private bank insurance schemes were to remain outside of SSI (I-13). Following the 2007 elections, in which the AK Party won additional seats in Parliament and gained control of the Presidency, the SSUHI Law was cleared of legal challenges by the Constitutional Court and passed into law in October 2008. As a result, in 2010 active civil servants were integrated into SSI and in 2012 Green Card beneficiaries became the last group to join SSI.

As of December 2012, the unified social security scheme had two contributory structures. The contributory scheme requires that all blue collar employees in the public and private sectors, active civil servants, white collar employees and the self-employed pay 12.5 percent of their pensionable salaries to SSI. Of this amount, employers are required to pay 7.5 percent and the remaining 5 percent is paid by the employee. The non-contributory regime, comprised primarily

of Green Card beneficiaries, involves a new means-testing system that is administered by the Ministry of Family and Social Policies (OECD, World Health Organization, and World Bank 2008).

Institutional veto points and Ministry of Health adoption strategies

We identified the institutional veto points that had the potential to block the reform (Section 5). We then asked our interviewees to indicate which institutions were sources of support or opposition. We found that the Parliament and Prime Minister were generally supportive of the reform. By contrast, we found that the reform faced strong opposition from people within the Council of Ministers, including the Ministry of Finance, Undersecretariat of Treasury, and the Ministry of Labour and Social Security, as well as from the President and Constitutional Court.

These five institutions formed three veto points: (1) the Ministry of Finance and Undersecretariat of Treasury, (2) the Ministry of Labour and Social Security, and (3) the Office of the President and the Constitutional Court. We analyze the Ministry of Finance and Undersecretariat of Treasury as a single veto point and the Office of the President and Constitutional Court as a single veto point because of the similarity in their points of opposition to the universal and unified financing system and the strategies used by Minister Akdağ to overcome the opposition at these two veto points. As shown in Table 2.2, each of these actors had the potential to block the reforms and either threatened or attempted to do so. All interviewees identified these veto points and their importance in structuring the policy adoption strategies of Minister Akdağ and his team. We analyze these three institutional veto points, their contestation of the reforms, the strategies used to overcome their opposition, and the institutional changes that occurred to move the policy adoption process forward (see Table 2.3).

Table 2.3: Institutional veto points to the adoption of a universal and unified health financing system and the adoption strategies used by Minister Akdağ and his team

Institutional Veto Point	Veto Power	MoH Adoption Strategies	Time Period that Veto Point Was Most Relevant
Ministry of Finance and Undersecretariat of Treasury	Capacity to block secondary administrative and primary legislative instruments from adoption due to discretion over budget and concern over government deficits	(1) Persuade Ministry officials, to gain support for secondary administrative and primary legislative instruments. (2) Avoid by using tertiary administrative instruments. (3) Take advantage of positive economic growth as a facilitating factor.	2003 - 2005
MoLSS	Capacity to block secondary administrative and primary legislative instruments from adoption due to prominent role in pre-reformed health financing and service delivery systems	(1) Persuade MoLSS officials, to gain support for secondary administrative and primary legislative instruments. (2) Compromise by using mutually beneficial primary legislative instrument. (3) Overpower by using Prime Minister's authority.	2003 - 2006
President and Constitutional Court	Capacity to block primary legislative instruments from adoption by referring laws to Constitutional Court, which could strike it down	(1) Avoid by using lower level administrative instruments. (2) Delay primary legislation and work to facilitate institutional change to reduce opposition. (3) Negotiate and make strategic compromises, to gain support for primary legislation.	2003 - 2007

Source: Authors

Veto point #1: Ministry of Finance and Undersecretariat of Treasury

The Ministry of Finance and Undersecretariat of Treasury leadership, acting primarily through the Council of Ministers, opposed any policy measures that would lead to larger public deficits. These two institutions worked closely together, with the Ministry of Finance responsible for setting fiscal policy and the Undersecretariat of Treasury responsible for managing financial assets. When the AK Party was elected in 2002 Turkey was just emerging from a decade of economic volatility, high and increasing public sector borrowing requirements, high interest rates, and increasing public sector deficits, all punctuated by a series of economic crises (Ertugrul and Selcuk 2001, International Monetary Fund 2002, Tatar et al. 2011). Although they were two

separate institutions, both the Ministry of Finance and Undersecretariat of Treasury were concurrently tasked by the Turkish Government and the International Monetary Fund to implement plans to address the government deficit, which was driven largely by high social sector spending (Boulton and Wolf 2002, Akyüz and Boratav 2003, International Monetary Fund July 2002, Alper and Alper 2003).

Strategic response: At the outset of planning the reforms in 2003, Minister Akdağ and his team first persuaded the Ministry of Finance and Undersecretariat of Treasury that a short-term increase in resources (to expand benefits and increase coverage) would lead to long-term efficiency gains and cost-savings (I-17). They did this in two ways. First, Minister Akdağ's team worked closely with technical experts from the World Bank to create detailed actuarial models that presented cost scenarios of different inputs, benefits packages, and service utilization (I-21, I-11, I-19). These projections provided evidence to the financing authorities that the MoH had carefully considered the budgetary implications and fiscal sustainability of their proposed plans. Second, they promoted the reform plan based on its objectives of increasing and expanding financial protection, and its potential to improve efficiency in the health system (I-20, I-11). Beyond expanding and unifying coverage, Minister Akdağ included provisions in the HTP to consolidate the public hospital system, increase primary care use through the introduction of the family medicine system, improve physician performance and reduce dual practice through performance-based incentives, introduce an information technology system to track all transactions in the health system, and strategically purchase health services from both the public and private sectors (Atun et al. 2013, Akdağ 2011, OECD, World Health Organization, and World Bank 2008). A completely universal and unified financing system would increase the potential efficiency gains

brought about by these supply-side interventions and promote financial sustainability in the long-run—the primary concern of the Ministry of Finance and Undersecretariat of Treasury.

As a second strategy, Minister Akdağ pursued policies that could be adopted under his own authority and hence did not require support from the Ministry of Finance and Undersecretariat of Treasury, which questioned the fiscal prudence of expanding the financing system. Minister Akdağ expanded benefits and increased coverage through lower level administrative mechanisms. He was able to do this for programs that were under the MoH's jurisdiction as long as the changes did not require overall increases in the MoH's budget as allocated by the Ministry of Finance (I-17). The primary vehicle for these changes was the Green Card Program for low-income individuals (I-4, I-5, I-11, I-17). The first step was to bring the Green Card Program and its related budget under the authority of the MoH. Prior to 2003, the Green Card Program had been funded through central budgetary allocations and paid for directly by Social Solidarity Funds controlled by the Prime Minister's Office (Menon, Mollahaliloglu, and Postolovska 2013). In support of the MoH, the Prime Minister transferred this budgetary authority to the MoH. This budget authority allowed the MoH and Minister Akdağ to change the benefits package and expand coverage without needing the approval of other institutions (I-4, I-5).

Veto point #2: Ministry of Labor and Social Security

The MoLSS opposed any measures that would diminish its power and influence in the health sector or that would decrease the benefits or services available for SSK beneficiaries (OECD, World Health Organization, and World Bank 2008, I-8, I-11). These were important consideration for Minister Akdağ and his team because at the start of the HTP, the MoLSS had more influence in health financing than the MoH because the MoLSS covered approximately 45 percent of the Turkish population through its SSK and Bağ-Kur systems (OECD, World Health

Organization, and World Bank 2008). To achieve Akdağ's goal of implementing a purchaser-provider split in the health system, all financing schemes had to be consolidated into a single institution and all health facilities transferred to the MoH or to an autonomous hospital board.

Strategic response: Minister Akdağ persuaded leaders of the MoLSS to support the reform by assuring them that there would be no reduction of entitlements for SSK beneficiaries. By contrast, his objective was to increase the entitlements of other beneficiaries to match Turkey's highest, those of retired civil servants under Emekli Sandığı. By doing so, Minister Akdağ ensured that most organized beneficiary groups and the MoLSS would not oppose the administrative and legislative instruments needed to adopt and implement the reformed system. Several informants involved in designing the reform reported that initially there were plans for a basic benefit package with options for supplementary care. However, in advance of parliamentary elections in 2007 the Council of Ministers chose to prioritize the political popularity of the reforms, over financial sustainability concerns, and therefore decided to offer a generous benefits package to all Turkish citizens (I-23, I-17, I-27, I-32). Language for supplementary insurance was included in the SSUHI Law appeal to the financing authorities, but this was inconsequential because the standard benefit package was expanded so much.

However, the MoH was unable to convince the MoLSS to transfer its SSK hospitals to the MoH. To overcome this opposition, Minister Akdağ and his team relied on direct intervention by the Prime Minister to overpower the MoLSS' veto. On the authority of the Prime Minister, the MoLSS's SSK hospitals were all transferred to the MoH in 2005. A negotiating strategy had not worked to gain the support of the MoLSS for this measure. Several informants told us that prior to the intervention by the Prime Minister, many had believed that the MoLSS would never relinquish control of its hospitals and that unification would be impossible (I-8, I-22, I-20). After months of

intense back and forth discussions between the MoH and MoLSS, the Prime Minister personally called the Minister of Labor and Social Security to inform him that all SSK hospitals would be moved under the MoH virtually overnight. The Prime Minister then introduced a bill in Parliament that was quickly passed to provide legislative support for this new policy (Hurriyet Daily News 2005).

To gain the support of the MoLSS for the financing component of the reform, Minister Akdağ compromised by combining his health reform plans with pension reform in Laws 5510 and 5502, which were put forward to Parliament in 2006. This meant that the establishment of the SSI and unification of all health financing schemes were packaged together with an increase in the national retirement age. The MoLSS was under substantial pressure to reduce the fiscal burden of pension obligations and hence favored an increase in the retirement age (I-11). The MoH leadership realized that the political viability of MoLSS's increased retirement age proposal could be advanced by bundling it with the much more popular proposal to expand health benefits (I-17, I-11). The move by Minister Akdağ to combine these different objectives ensured that the MoLSS would support the adoption of the primary legislative instrument needed to unify the health financing system.

Veto point #3: The President and the Constitutional Court

The President and Constitutional Court constituted a significant veto point to the universal and unified financing system. We consider the President and Constitutional Court together in this analysis because the President's veto power rested on his ability to refer legislation to the Constitutional Court for review and his ability to influence the Court by appointing its members. From May 16, 2000, until August 28, 2007, the President of the Turkish Republic was Ahmet Necdet Sezer, who had been elected by the Parliament before the AK Party came to power. Sezer

had been President of the Constitutional Court from 1998 to 2000 and was the first Turkish head of state to come from the judicial branch. Although he was not affiliated formally with any political party, he was a strong defender of secularism and as such often opposed AK Party initiatives (Ersoy 2007, I-5, I-2).

Once Laws 5510 and 5502 were passed by Parliament in 2006, they were forwarded to the President's office for final approval, which was granted in the former case. However, in the latter case, President Sezer referred Law 5502 (SSUHI Law) to the Constitutional Court because he believed it was unconstitutional. He argued that civil servants, as "owners of the Republic," should not be part of the same law or social security system as the rest of the Turkish citizens (I-5, I-11, I-17, Yasar 2011). He was particularly opposed to the provision increasing the retirement age from 48 years for women and 52 years for men to 65 years old for the entire population (I-11, I-5). The Constitutional Court agreed with President Sezer's concerns and nullified the articles in the SSUHI Law pertaining to active civil servants. As a result, the full unification of the health financing system was blocked in 2006, but not permanently.

Strategic response: Minister Akdağ and his team avoided this veto point by expanding and unifying the health financing system as much as possible through secondary and tertiary administrative instruments before introducing primary legislation in 2006 (I-5, I-27). As long as coverage expansions and benefits packages increases took place through regulations, ministerial directives, or circulars, President Sezer and the Constitutional Court could not exercise their veto power to block them (I-23, I-11, I-13). This staged adoption and implementation process also served to gain public support for the AK Party's health reform agenda, which helped support the party in the 2007 election and thereby helped generate support for institutional change.

Although Minister Akdağ and his team could not avoid the veto power of the Office of the President and Constitutional Court for the SSUHI Law, they delayed putting forward primary legislation as long as possible while President Sezer was in office until mid-2007. While doing so, Minister Akdağ focused on building electoral support for the AK Party's health reform agenda in advance of the 2007 presidential elections. In August of that year Abdullah Gül, a prominent member of the AK Party, was elected President as the successor of Sezer. Gül's candidacy was initially blocked by the Constitutional Court in May 2007 due to questions over his commitment to secularism (Ersoy 2007). However, after the AK Party won 47 percent of the popular vote in July 2007, Gül was elected easily as the new President (Hale and Özbudun 2010). With Gül's election, both the Office of the President and the Parliament were controlled by the AK Party for the first time. This ended the opposition from the Office of the President to the unification of financing systems under the health reform.

Minister Akdağ still had to make strategic compromises on the provisions of the SSUHI Law that pertained to current and retired civil servants to finally remove the Constitutional Court's opposition to the law. President Gül could have exercised his authority to appoint new judges more sympathetic to the law, but when he took office he had other priorities. To finally adopt the SSUHI Law, Minister Akdağ and the Minister of Labour and Social Security agreed that the new social security requirements would only pertain to civil servants hired after October 2008—effectively exempting existing civil servants and neutralizing their opposition, which was enough to end the Constitutional Court's opposition to the law (I-17, I-2, I-5).

Discussion

This use of Immergut's institutional veto points theory to analyze health reform in Turkey provides further evidence that institutional veto points shape the reform of health systems. Our analysis, however, goes beyond the original theory to examine the strategies used to overcome opposition at each of the three veto points in Turkey. Although we present a single case, we are able to increase leverage over our hypothesis about how institutional veto points structured Minister Akdağ's policy adoption strategies by building on Immergut's analysis (King, Keohane, and Verba 1994). We begin our analysis with the same motivating questions that Immergut used in her three case studies—why does Turkey have a universal and unified financing system? We then also apply the institutional veto points theoretical framework to the reform process in Turkey. However, we find that in the case of Turkey the key explanatory variable in determining Turkey's outcome was not how institutional veto points structured interest group influence. Rather, in this minister-driven reform, it was how these institutional veto points structured the strategic actions of Minister Akdağ to promote the adoption of his desired policies.

The Turkish case is an example of minister-driven reform, which shows how a minister can move reform forward even when faced by opposition at three institutional veto points. Instead of focusing on how institutions constrained interest group influence, as Immergut did, we instead show how institutions constrained policy adoption but also how political leaders could adopt multiple political strategies that finally circumvented the veto points. This analysis argues that institutional veto points do not exist in a political vacuum; instead, the analysis shows how political actors (Minister Akdağ and his team, in this case) can take advantage of different institutional opportunities to construct a process that resulted in policy adoption.

Our analysis identifies four key strategies that enabled Minister Akdağ to achieve his policy objective.

First, *avoid*: Minister Akdağ used an intentional legislative strategy that emphasized secondary and tertiary administrative instruments to avoid the likely veto of the President and Constitutional Court (if primary legislation were proposed). Attempting to begin the reform using primary legislation would have stalled adoption until after the 2007 elections. Instead, Minister Akdağ was able to adopt and implement much of the reforms far earlier by using lower level ministerial directives, circulars, and regulations, and he postponed primary legislation as long as possible. He and his team worked to gain the support of other ministries with vested interests in the reform process and therefore could rely on their support in adopting these lower level administrative instruments. When he eventually needed primary legislation to fully adopt the unified system, the SSUHI Law was written so that it was flexible and open-ended to allow for as much discretion as possible during implementation (I-5, I-12, I-4). Therefore, the particulars of the new financing system would still be decided by Minister Akdağ and his fellow ministers through the continued use of administrative instruments. This adoption strategy should be viewed as part of the broader AK Party approach to policy reform, which has sought to overcome potential institutional opposition by circumventing the formal adoption process laid out in the Turkish Constitution.

Second, *delay action while facilitating institutional change*: Minister Akdağ's use of tertiary level administrative instruments to adopt coverage expansions provided benefits to the Turkish citizenry that created important political consequences for the AK Party. Public satisfaction with the health system increased dramatically in the early years of the reform thanks in part to the increase and expansion of benefits for both Green Card holders and SSK beneficiaries

that occurred through ministerial directives and circulars (Turkish Statistical Institute 2003). This public support helped win additional votes in Parliament, and also helped the AK Party make electoral gains in the 2007 Parliamentary elections. This increased electoral support was ultimately the lynchpin of the strategy because it gave the AK Party enough seats in parliament to capture the Office of the Presidency, replace Sezer with Gül, and align the Presidency with the AK Party's policy agenda and Minister Akdağ's health reform plans. This second adoption approach also reflected the broader AK Party approach to facilitating their policy agenda, by reconfiguring key political institutions, including the Constitution itself, and creating special economic zones.

Third, *persuade and compromise*: Minister Akdağ and his team created a new organization for negotiating with other government agencies to reduce bureaucratic politics and lower the likelihood of opposition to secondary administrative and primary legislative instruments. Shortly after coming into office, Minister Akdağ established an inter-ministerial working group that was comprised of leaders from the MoLSS, Treasury, Ministry of Finance, and the Ministry of Development (formerly State Planning Organization), all of whom had a vested interest in health reform. It did not include ministers themselves—members were senior leaders with technical expertise and political experience to directly influence their ministers (I-5, I-15, I-17, I-11). This membership reflected the intention that the new group focus on the technical aspects of the reform. Once the group reached conclusions, each member was responsible for convincing his minister to support the position. For instance, the representative from the MoLSS was one of the few bureaucrats from that ministry that was in favor of the unified system (I-11). This working group was also the venue where Minister Akdağ's team presented the detailed actuarial models to Ministry of Finance and Treasury colleagues to convince them of the financial sustainability of the reformed system. Importantly, the members of this working group agreed to engage in vigorous

policy debate without losing sight of their ultimate objective of a reformed health system (I-5). This agreement ensured that discussions and negotiations would continue even with disagreements. This working group allowed Minister Akdağ to incorporate the concerns of other ministries in the reform process and thereby gain the support of other ministries. He involved these policymakers in the planning and design of the reform to generate support for the adoption of his policies and for the later stage of implementation

Fourth, *overpower*: Minister Akdağ used the power and support of the Prime Minister to override the opposition of other ministries to his proposals. Several interviewees and a published report cited Minister Akdağ's close relationship with Prime Minister Erdoğan and the importance of health reform within the AK Party agenda as factors that gave Minister Akdağ exceptional power and influence within the inter-ministerial working group and the Cabinet to push forward his policy agenda (Johansen and Guisset 2012, I-15, I-17, I-27, I-8). Minister Akdağ was able to leverage this power to ensure that the Council of Ministers remained engaged with his health reform plans despite pushback from the Ministry of Finance and MoLSS. He could also rely on the Prime Minister's strategic intervention when he was not able to gain the support of these two ministries on his own accord.

This study has several limitations. We do not contend that our analysis is the only possible explanation for the adoption of Turkey's health reform. There were other hurdles that were overcome, ranging from interest group opposition, technical difficulties, financing constraints, resource shortages, and public behavior change issues. As discussed above, our explanation is given additional credibility based on the comparisons that can be drawn to the previous failed attempts to achieve a similar policy objective in Turkey, as well with Immergut's three case studies that also show the importance of potential veto points to policy adoption. We are also limited by

our use of interview data. Our analysis may suffer from recall bias because it concerns events in the past. Interviewees may not have been entirely forthcoming in their responses or linguistic issues could have constrained their ability to fully respond to or understand questions. We try to overcome these issues through triangulation of data and accounts; however, some bias may still exist.

Conclusions

Minister Akdağ and his team in the MoH carefully crafted their policy adoption strategies to address and overcome opposition at three institutional veto points that posed the largest threats to the adoption of their ambitious health reform. This analysis finds support for Immergut's argument of the importance of institutional veto points and how they can serve as major obstacles to the adoption of health reform. We go beyond this finding to show that political leaders promoting reform can, in some instances, design political strategies that overcome opposition at institutional veto points—in ways that can raise the political feasibility of a reform and lead to successful policy adoption (Reich 2002). In this instance, Minister Akdağ diminished the blockages at veto points by avoiding some through the use of lower-level administrative instruments to adopt changes to the health system, by delaying action while facilitating changes in institutions that opposed his reform policies, by persuading and making strategic compromises with key opponents, and by overpowering opponents at specific institutional veto points through executive actions taken by the Prime Minister. This application and extension of Immergut's institutional veto points theory to the case study of Turkish health reform provides an example of a strategic approach to policy adoption that other countries may learn from to increase the likelihood of the adoption of their own reform agenda.

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CHAPTER 3: BANNING DUAL PRACTICE FOR PHYSICIANS IN TURKEY THROUGH A “DIVIDE AND THEN CONQUER” STRATEGY

Introduction

Physicians are typically among the most influential groups in any health system reform. As a major provider of healthcare services, they have extensive training and considerable proprietary technical expertise, which give them high status in society. As a profession, they have a legal monopoly on medical practice and tend to be well organized with access to political resources. As a result of this combination of influence and power, physicians, as an organized collective, are often portrayed as veto players to health reform (Immergut 1992, Marmor and Thomas 1972). Veto players are “individuals or collective actors whose agreement is necessary for a change in the status quo” (Tseblis 2002, 36). Based on this characterization, a policy reform can be blocked if physicians, or specifically medical associations as representatives of physicians’ collective interest, are opposed to it (Marmor and Thomas 1972, Eckstein 1960, Immergut 1992). Despite this ability, we know that health system reforms continue to take place that alter how physicians are paid and employed, with the Affordable Care Act in the United States as a recent notable example (American Medical Association 2009).

The recent effort to ban “dual practice” was an important component of Turkey’s large-scale and comprehensive health system reform known as the Health Transformation Program (HTP) (2003-2012). The outcome of that effort provides an opportunity to examine a reform that was introduced despite the strong opposition of the Turkish Medical Association (TMA). The Law on Full-Time Medical Practice of University and Public Sector Health Personnel (hereinafter, Law on Full-Time Medical Practice) was legislated in 2010 and fundamentally changed the structure of medical practice in Turkey by officially barring Ministry of Health (MoH) physicians from

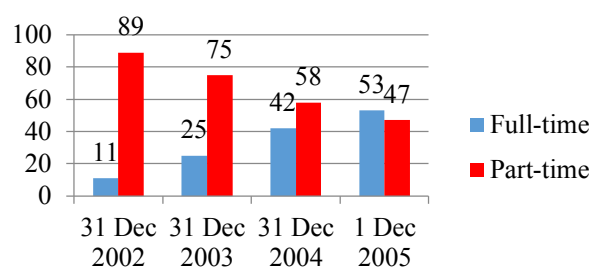
concurrently practicing medicine in the public and private sectors. It was put forward by the MoH as a mechanism to increase the availability of physicians in the public sector to meet the increased demand for services brought about by the expansion of health insurance coverage and benefits under the HTP (Akdağ 2009).

The process of banning dual practice occurred within the political context of the newly-elected Adalet ve Kalkınma Partisi (AK Party) Government. The AK Party was formed in 2001 and came to power in November 2002 by winning 34.3 percent of the popular vote, which resulted in garnering almost two-thirds of the seats in Parliament (Heper 2003, Özbudun 2006). It was seen as the reformist offshoot of the Islamist-oriented Virtue Party, which was banned in June 2001 by the Turkish Constitutional Court due to violations of the secular principle in the Turkish Constitution (Özbudun 2006). Physicians, and in particular the TMA, were not typically part of the AK Party's electoral base. Rather, physicians tended to be aligned with opposition parties that upheld strong secular beliefs (Agartan 2005, I-14, I-10, I-16). By contrast, the AK Party drew its power from a coalition of rural populations, artisans, small traders in cities, urban slum dwellers, and the rapidly rising 'Islamic bourgeoisie' (Özbudun 2006). As such, the AK Party prioritized the greater availability of health services to the general public over the potential risk of antagonizing the TMA with its policy agenda.

At the start of the HTP, dual practice in Turkey was legal and well-established. It provided an important source of additional income for physicians, who had a strong interest in maintaining the status quo (Yasar 2011). The Turkish MoH data show that as of 2001, approximately 89 percent of all public sector specialist physicians and 60 percent of all physicians maintained private sector practices in addition to their public sector employment (Figure 1) (Vujicic, Sparkes, and Mollahaliloglu 2009, OECD, World Health Organization, and World Bank 2008). Physicians

engaged in dual practice could earn up to five times more than their counterparts working exclusively in public practice (Vujicic, Sparkes, and Mollahaliloglu 2009). An earlier attempt to end dual practice in the 1970s was abandoned in the face of strong opposition from physicians who sought to preserve for themselves the financial advantages of the system (Tatar et al. 2011, Akdağ 2009).

Figure 2.1: Share of Specialist Physicians Working Full-Time and Part-Time in the Public Sector



Source: Turkey Ministry of Health data

While the official legislation to ban dual practice for MoH physicians was adopted by the Turkish Grand National Assembly in 2010, efforts had been underway since the start of the HTP in 2003 to draw physicians into full-time public sector practice. The MoH began providing large financial incentives for public sector physicians to give up their private sector practices through its Performance-Based Pay System (PBPS) in 2004 (see Section 5, below). These efforts paid off, and by 2005 the MoH estimates that 53 percent of specialist physicians were practicing full time in the public sector (Figure 1) (Vujicic, Ohiri, and Sparkes 2009). The 2010 Law on Full-Time Medical Practice required health-care professionals working in MoH facilities to work exclusively in the public sector and discontinue any work in the private sector (Tatar, Mollahaliloglu et al. 2011). The 2010 Law included an exception for physicians practicing in public university hospitals, after a challenge in the Constitutional Court. Unlike MoH physicians, they were allowed to see patients in their private practices after 5 pm but only once their teaching- related activities were completed during normal business hours.

Turkey's dual practice system was similar to the system in many other countries. With a few notable exceptions, dual practice continues to be the norm in both developing and developed countries (García-Prado and González 2007). Relatively few countries have put into place outright bans on dual practice. As of 2011, only Canada, China, Turkey and some states in India had successfully banned dual practice (García-Prado and González 2011). This may be because these bans are hard to enforce, particularly in areas with weak regulatory capacity (Jan et al. 2005). Other countries have sought to limit dual practice through a mixture of regulation and incentives (García-Prado and González 2007, Socha and Bech 2011). Given the global prevalence of dual practice systems and the limited attempts to adopt outright bans, it is important to understand how Turkey was able to curtail and then abolish this system.

This paper presents a case study of how the Turkish Minister of Health Recep Akdağ (2002-2013) and his team of advisors overcame opposition from the TMA and its base of university physicians between 2003 and 2010 to adopt the ban on dual practice. We argue that he used a divide and then conquer political strategy, where he acted to exploit coordination problems among physicians by appealing to the individual interests of physicians and undermined the authority of TMA and its base of university physicians (Posner, Spier, and Vermeule 2010). We show that by “dividing and then conquering” physicians in Turkey, Minister Akdağ diminished the power of the TMA, while reducing resistance from individual physicians who could gain from remaining neutral or supportive of his efforts. We argue that this divide and then conquer strategy created a favorable political environment to ban dual practice and expanded the capacity of public health services so that they could meet growing patient demand. We briefly discuss the consequences of this strategy for physicians and the health system in general, but without undertaking a full evaluation of the consequences of banning dual practice.

The paper is organized as follows: Section 2 describes the conceptual framework used to motivate and structure the analysis; Section 3 provides a brief review of literature on the role of physicians in health reform and dual practice; Section 4 describes the data and methods used; Section 5 uses the divide and conquer conceptual framework to analyze the actions taken by Minister Akdağ between 2003 and 2010 to facilitate the ban on dual practice; Section 6 discusses the implications and lessons that emerge from this analysis and the limitations of this analytical approach; and Section 7 provides a brief conclusion.

Conceptual Framework

The conceptual framework for this paper is based on the model of “Divide and Conquer” presented by Posner, Spier and Vermeuele (2010). Their model is derived from the modern political concept of “divide and conquer” or “divide and rule” (divide et impera), which dates back to at least the 16th century when Machiavelli wrote that a military commander can divide the forces of his enemy by making him suspicious of his own trusted men or forcing him to separate his forces (Machiavelli 1521). Immanuel Kant (1795) continued this line of reasoning in encouraging political leaders to incite conflict among privileged members of society to set them at odds with society more broadly. This strategy would allow a leader to protect the weak and divide the ruling class, and thereby increase the likelihood of retaining power.

Posner, Spier and Vermeuele (2010) decompose the general divide and conquer strategy to show how strategies that provide incentives, threaten or disadvantage, and communicate messages can be used to divide and conquer both organized and unorganized groups. The authors draw from historical, political, sociological, and economic texts to develop their proposed strategies and then use game theory to demonstrate how policymakers can apply these strategies to exploit coordination problems among groups of players. To use their model of divide and conquer

strategies a unitary actor bargains with or competes against a set of multiple players. The unitary actor can use divide and conquer strategies to alter the benefits of the multiple players to try to induce at least one player to work with her. The basic idea behind these strategies is for the unitary actor to reduce the potential for players to organize collectively based on their concentrated and uniform interests (Olson 1965). Collective action on the part of an organized group can allow it to exert influence on policy outcomes, even if its members only represent a minority of the population.

Collective action on the part of physicians is common, particularly if physicians are dissatisfied with their working conditions or with a proposed policy change (World Medical Association 2012). However, different preferences among physicians can lead to a potential lack of unity and reduce the likelihood or effectiveness of collective action. In the case of Turkey, the TMA was the official professional association representing physicians. Its membership was obligatory for all physicians practicing in the private sector, which was the majority at the start of the reform (Turkish Medical Association Central Council 2006, Turkish Medical Association 2013). As we present in Section 5, there were several classifications of physicians that the TMA and Minister Akdağ had to consider, including: MoH physicians (~66 percent in 2002), university physicians (~21 percent in 2002), and private sector physicians (~13 percent in 2002) (see Table 3.2) (Vujicic, Sparkes, and Mollahaliloglu 2009). We argue that Minister Akdağ and his team of advisors within the MoH (as the unitary actor) sought to strengthen divisions among these groups of physicians (multiple players) to reduce the potential power of the TMA to block the ban on dual practice. They took actions to appeal to the individual interests of MoH and some private sector physicians to reduce their resistance to the ban on dual practice and encourage their participation in the national health insurance system that was part of the HTP. He also worked to delegitimize

the TMA's authority in the health system and neutralize through disincentives its base of elite, university physicians, so that they could not completely block the ban on dual practice when it was put forward in 2010.

Review of relevant literature

Role of physicians in health reform

The literature on the role of physicians in health system reform tends to focus on the ability of a medical association, as a vehicle to express physicians' interests, to block reforms or influence reforms in their favor. For example, Marmor and Thomas (1972) compare disputes over methods of payment between the British Medical Association and the British government, as well as between physicians and governments of other developed countries in the 1950s and 1960s, to find evidence in support of their general hypothesis "Whatever the political and medical structure of a western industrial country, physician preferences determine the governmental methods of payment" (Marmor and Thomas 1972, 435). The authors argue that although physician payment methods differ across countries, they share a "remarkably close resemblance to what physicians were used to before programs began" (Marmor and Thomas 1972, 28). As Kwon and Reich (2005) show in the case of South Korea, physicians' power is derived in large part from their strategic use of labor strikes to protect their interests.

Immergut (1992) also stresses the potential for physicians to influence policy outcomes, but she finds that they do not always act as veto players to reform. She argues, instead, that their ability to influence policies is determined by the formal institutional processes for policymaking. She does not, however, go beyond these formal processes to examine the political strategies that policymakers can use to manage physicians' influence. This case study adds to the literature on the influence of physicians on health system reform by focusing on how physicians, and in

particular the TMA and its base of university physicians, were managed by policymakers in the Turkish reform. Our analysis shows how the strategic actions of a reform leader can produce policy adoption.

Dual Practice

There are relatively few studies examining the role of dual practice in health systems. The existing literature focuses on the financial and non-financial incentives for physicians to engage in dual practice, as well as the consequences of dual practice on the health system in general (Berman and Cuizon 2004, García-Prado and González 2011, Chawla 1996, González 2004, Socha and Bech 2011). A 2010 Cochrane review of dual practice by Kiwanuka et al. finds that dual practice was driven by inadequate public sector salaries and growth in the unregulated private sector. The desire to have public sector job security, while also taking advantage of professional training opportunities available in the private sector, can also motivate dual practice behavior (Ferrinho et al. 2004).

The impact of dual practice on a health system can be large. From a theoretical standpoint, dual practice can decrease public sector physicians' labor supply, resulting in lower overall provision of health care in the public sector (Brekke and Sørsgard 2007). Studies examining the effects of dual practice show that it can lead to: induced demand for service in the private sector; brain drain to other countries; competition for physician time; absenteeism; tardiness; misallocation of resources; and decreased quality of public sector care (Kiwanuka et al. 2010, Socha and Bech 2011, Hicks and Adams 2000). Dual practice can also have positive effects by compensating for low public sector salaries and retaining highly skilled physicians in the public sector (Kiwanuka et al. 2010).

There are only a few studies that examine how to regulate, limit, or abolish dual practice. These cross-country studies review policies to alter dual practice behavior, their implications for health service delivery, and where these policies have been implemented (Socha and Bech 2011, García-Prado and González 2007, Jan et al. 2005). However, unlike this case study, they do not use theory or delve into the political strategies used to adopt these policies, particularly within a single country.

Data

The study employed qualitative method of inquiry. Primary data for the study were collected through semi-structured interviews of key informants. Additional data were gathered through a review of both published and grey literature.

Interviews

The interview process was multi-staged. Initial interviews took place between March and May 2013 in Ankara and Istanbul, Turkey, and Washington, DC. These interviews were conducted by Susan Powers Sparkes and Jesse B. Bump as part of a World Bank project on the political economy of the HTP (Bump and Sparkes 2014). We used a purposive sampling to have a reach groups with vested interests and expertise in the reform process (Maxwell 2013). To identify these groups we first hypothesized that the important stakeholders in the Turkish health system reform would be roughly similar to stakeholder groups important in other health system reforms. Based on a literature review and experience in other countries, we constructed a preliminary list of these stakeholders to interview, which we then refined according to published articles on Turkey and the views of counterparts at the General Directorate of Health Research of the MoH in Turkey, and at the World Bank's office in Ankara and its headquarters in Washington, DC.

As we conducted interviews and improved our understanding of the relevant actors, we used ‘snowballing’ to adjust the stakeholder table and interviewee list (Goodman 1961). To help ensure consistency and completeness, we used a semi-structured interview guide. Data were analyzed iteratively with the merging themes informing subsequent rounds of interviews with additional key informants.

Sparkes conducted two subsequent rounds of interviews after the initial set. These second and third round of interviews focused on questions about Minister Akdağ’s strategic actions related to HTP reforms that affected health workers. In the second round of interviews, Sparkes collected extensive qualitative interview data through 10 one-on-one in-depth interviews and group discussions with Minister Akdağ (2002-2013) between September and November 2013 after he left office in June 2013.

The first two rounds of interviews provided a first-hand account of Minister Akdağ’s actions and thinking related to the reform. From these interviews, the hypothesis emerged that he achieved his objective of banning dual practice through a strategy of “divide and then conquer.” The third round of semi-structured interviews took place in January 2014 in Ankara and Istanbul and asked key informants about the specific actions Minister Akdağ took to divide physicians in advance of putting forward legislation to ban dual practice, and how these actions affected the position of physician groups with respect to the ban on dual practice. We again used a purposive sampling to ensure that the perspectives of MoH officials, MoH physicians, university physicians, private sector physicians, and the TMA were taken into account (Hardon, Hodgkin, and Fresle 2004, Maxwell 2013).

In total, we held 54 separate in-depth interviews with representatives from the Turkish government, medical related professional associations, academia, individual health professionals,

and the World Bank. The interviews were arranged with assistance from colleagues at the MoH, and independently based on our own contacts within Turkey. The list of interviewees and their affiliations is presented in Table 3.1.

Interviews were conducted either in English, in a mix of Turkish and English, or in Turkish with professional interpretation, according to circumstances. Each interviewee was informed of the purpose of the study, of the authors' intention to take detailed notes of each interview, and of the authors' process for handling interview data. The authors requested permission to take notes and to report quotes attributed to a general affiliation. Institutional Review Board (IRB) approval was granted for this study (IRB13-1294) and deemed exempt by Harvard School of Public Health's Office of Human Research Administration. Interviews are cited in this paper according to the number assigned to the interviewee.

Table 3.1: Interviewee Affiliations

Affiliation*	Interviewee List (number of interviewees in parenthesis)		
	Round 1	Round 2	Round 3
Government (Total interviewees=27)	MoH (12), Ministry of Labour and Social Security (2), Ministry of Family and Social Policy (2), Undersecretariat of Treasury (1), Ministry of Development (4), Turkish Statistical Institute (1), Higher Education Council (1), Parliament (4)	MoH (1)	MoH (8), Ministry of Labour and Social Security (2), Parliament (1), Undersecretariat of Treasury (1)
Professional associations (Total interviewees=9)	Turkish Medical Association (4), Turkish Midwives Association (2), Turkish Nurses Association (2), Sağlık-Sen (1)		Turkish Medical Association (2)
Academia (Total interviewees=6)	İstanbul University (1), Hacettepe University (2), Yıldırım Beyazıt University (1), Kırıkkale University (1), Medipol University (1)		Hacettepe University (2), Medipol University (1)
Individual physicians (Total interviewees=12)	Private sector (1), MoH (4), University (7)		Private sector (1), MoH (3), University (4)
International organization (Total interviewees=5)	World Bank (5)		

* Interviewees may have multiple affiliations and the same interviewee could be interviewed in more than one interview round.

Source: Authors

Literature review

We conducted an extensive literature review of grey and published literature on Turkey's health reform to develop and analyze the underlying hypothesis, and in order to triangulate data to reduce possible bias introduced through stakeholder interviews (Maxwell 2013). We systematically searched empirical, experimental, and observational studies, as well as policy documents, reports, and newspaper articles using Google Scholar and PubMed. Key words for collecting materials included: 'health reform in Turkey' (39 studies included), 'the Health Transformation Program' (in abbreviation and full name) (39 studies included), 'political economy of the AK Party' (13 studies included), 'physicians in Turkey' (12 studies included), 'dual practice' (12 studies included), and 'divide and conquer strategies' (seven studies included).

We used Google translate for all source material written exclusively in Turkish. Though not an ideal method of translation, Google translate provided sufficient information to confirm or negate information collected through interviews. Translated Turkish documents were only used to triangulate data collected from other sources and were not used as a primary source due to the limitations of computer translation.

Analysis

Variables

Outcome variable: The outcome variables for this analysis are (1) the change in position (opposed, neutral, or supportive) of MoH physicians, university physicians, private sector physicians, and the TMA with respect the ban on dual practice or (2) the change in power of MoH physicians, university physicians, private sector physicians, and the TMA in the Turkish health system.

Explanatory variables: The explanatory variables for this analysis are two-fold. (1) Actions taken by the Minister and his team that served to reduce opposition or gain the support of physicians between 2003 and 2010. (2) Actions taken by the Minister and his team that served to delegitimize or penalize groups of physicians between 2003 and 2010.

Methods

Data collection and analysis was undertaken iteratively (Maxwell 2013). This analytical approach provided the necessary background to form relevant and theory-based hypotheses on how the ban on dual practice was adopted in Turkey. These hypotheses could then be explored and carefully analyzed through follow-on rounds of in-depth interviews. After the first phase of interviews, we conducted a stakeholder analysis to assess relevant actors' objectives and roles in the reform process, as well as the political strategies they used to try to achieve their reform objectives. From this first analytical step, the tension between the TMA and the MoH emerged as a key issue surrounding the adoption and implementation of the HTP. It also became clear that individual physicians, based on their affiliation (MoH, university, private sector), held strikingly different positions and interests in the HTP reform process that did not always align with the position and interests of the TMA.

The second step in the analysis was to analyze the interview data to identify the actions taken by Minister Akdağ and his team of advisors to reduce physicians' resistance to the ban on dual practice or penalize physicians remaining in opposition. We used a 'process tracing approach', where we "trace the temporal and possibly causal sequences within my case that intervene between independent variables and the observed outcome" (Bennet and George 2001, 144). In this way, the identified explanatory variables are steps in the staged process Akdağ took to adopting the ban on dual practice, which culminated with the 2010 legislation (as the final

outcome of interest to explain). In the third step, we coded how each of the identified actions (explanatory variables) affected the position (opposed, neutral, or supportive) of each of the four physician categories (MoH, private sector, university, and TMA) relative to the ban on dual practice. This determination of physician position came directly from interview responses, as well as our analysis of which categories of physicians stood to benefit or lose from each action.

Case Study: dividing physicians to ban dual practice in Turkey

Physicians in Turkey

Our analysis examines the position and power of individual physicians, as well as physicians as an organized collective, with respect to the ban on dual practice. In this section, we describe the broad categorizations that we use for individual physicians (MoH, university, and private sector) and present background on the TMA and its role in the Turkish health and political systems. These categories are important because the actions taken by Minister Akdağ and his team affected physicians in different ways and the opportunity to benefit from dual practice also varied across physician categories.

The total number of physicians practicing medicine in Turkey increased dramatically after the start of the HTP. In 2002, there were 94,466 physicians practicing and by 2011 there were 126,029 (Republic of Turkey Ministry of Health 2013). As shown in Table 3.2, there was a large increase in the number of private sector physicians both relative to the overall physician workforce and in total numbers. However, the majority of physicians remained employed by the MoH, with approximately one-fifth of physicians affiliated with university hospitals (Table 3.2).

Given the prevalence of dual practice in Turkey prior to the HTP reforms, most physicians stood to lose from an outright ban on dual practice if no other action were taken to compensate them for the expected loss of income. Interviewees reported that prior to the HTP, if there were

supposed to be five physicians working in a health facility, one would see public sector patients and the rest would either charge patients for services or engage in non-health service delivery activities (I-15, I-5). This system was seen as a drain on the health system, but also as a way to compensate public sector physicians for their low government salaries.

Table 3.2: Physician Categories and Potential Impact of Dual Practice Ban as of 2002

Physician category	Share of total physicians in 2002	Share of total physicians in 2011	Potential impact of ban on dual practice
Ministry of Health	68%*	58%	The majority could lose income by giving up private sector practices.
University	21%	21%	Would have to give up private sector practice and could have incomes dramatically reduced given large demand for services.
Private Sector [‡]	13%	21%	Could lose income if there were greater availability of services in the public sector.
Turkish Medical Association	~80%**	~75%***	As representative of all private sector physicians as a licensing requirement, its membership could drop if there were fewer physicians in the private sector. Strong base of university professors could experience the most adverse effects from ban due to high demand for their specialized services.

[‡] Includes physicians *only* working in the private sector and not those engaged in dual practice.

* Includes “other public” physicians from Ministry of Defense and Ministry of Labour and Social Security.

** Estimate as of 2006 (Turkish Medical Association 2013).

*** Estimate from interviews with TMA officials.

Source: Turkey Ministry of Health, General Directorate for Health Services 2012, Department of Strategy Development Health Statistics, 2001-2005, Directorate of Personnel, 2006 and December 2007 studies, SPSS statistical yearbooks

Although university physicians were a minority group, they were influential in the health system as academic clinicians working in well-regarded university hospitals. These professors were the most vocal in their opposition to a ban on dual practice. They were employed by the Turkish Higher Education Council (Yüksek öğretim Kurulu or YÖK), and not by the MoH. However, they were also public sector employees and therefore subject to general civil service guidelines and would be affected by a potential ban on dual practice. They were highly skilled and often in high demand in both the public and private sectors. As academic elites, the majority were in staunch opposition to the AK Party government due in large part to concerns about maintaining

secular governance in Turkey. These university physicians formed the base of the TMA and therefore had significant influence in the organization (I-17, I-14).

The TMA is the primary professional association representing physicians in Turkey, and had approximately 80 percent of all physicians as members in 2006 (Turkish Medical Association 2013). It was founded in 1928 at the start of the Turkish Republic and initially all physicians in Turkey had to be members. However, after the 1980 coup in the country, only physicians practicing in the private sector had to be members as a licensing requirement (Agartan 2005b, Turkish Medical Association 2013). According to Turkish law, the TMA does not have any collective bargaining power and serves only an advisory role. The TMA also has weak links with the legislature, particularly after the AK Party's sweeping victory in the 2002 election (Agartan 2005b). The TMA has remained in opposition to the AK Party based in large part on ideological differences. The TMA favors a state-centered National Health Service model and the AK Party's HTP agenda put forward a national health insurance model with a large role for the private sector through contracting (Agartan 2005b). These differences on health system visions even led to the former Prime Minister Recep Erdoğan referring to the TMA as “outdated communist remainders” (14 Mart Sağlık Haftasında 2006, Agartan 2005b).

Actions

Through the HTP, Minister Akdağ and his team of advisors set out to improve Turkey's physician workforce that was plagued by absolute shortages and an unequal geographic distribution (Vujicic, Sparkes, and Mollahaliloglu 2009). Increasing training capacity and output would take time. In the short-term, they had to rely on the current stock of physicians in the country to meet increased demand for health services brought about by the HTP (I-5).

Public sector doctors were paid a salary based on civil service rules. Salaries of doctors in the public sector were the same, whether in MoH or university hospitals. But they were so low (approximately US\$400-500 per month) that almost 60 percent of all public sector physicians also practiced in the private sector in 2003 (OECD, World Health Organization, and World Bank 2008). As a result, staff absenteeism was widespread in public facilities. In an attempt to retain providers at public facilities, doctors in government facilities were officially allowed to see private outpatients in their hospital after 4pm—which only encouraged them to refer any patients they thought could pay to their after-hours private sessions (World Bank 2003). In practice, this time restriction was not enforced and public sector physicians would see private patients before 4 pm as well (I-5, I-14, I-8, I-17). Minister Akdağ and his team of advisors identified ending this dual practice system as the necessary step to improve physician availability in the public sector. In interviews, he referred to ending dual practice as one of the most important components of the HTP, because he viewed it as a key cause of high rates of catastrophic spending, dissatisfaction with the health system, and the inability to access care in the pre-reformed health system (I-5).

This section presents the four key actions taken by Minister Akdağ and his team of advisors in advance of putting forward the Law on Full Time Practice for adoption in 2010. We do not consider all health workforce-related HTP initiatives in this analysis. We focus on “dividing” actions referenced by government officials and physicians in interviews as either critical to reducing opposition from individual physicians or to delegitimizing/penalizing those physicians remaining in opposition. The actions that we identified include: (1) the introduction of pay for performance system; (2) contracting with private sector physicians; (3) establishment of MoH-affiliated university hospitals; and (4) increasing the membership of a health worker union aligned with the AK Party. We discuss each of these actions, their strategic consequences on physicians’

interests and positions, and their contribution to the eventual ban on dual practice (i.e., conquer) (see Table 3.3 for a summary of findings).

Table 3.3: Actions to divide physicians in Turkey and related political strategies, 2003-2010

Action	Objective	Strategy to gain support or reduce opposition	Strategy to penalize or deligitimize opposition
Introduce pay for performance system	Increase availability and improve performance of physicians in public sector.	Provided financial incentives for physicians to work full-time in public sector	(1) Performance metrics disadvantaged university physicians by not including teaching and research activities and (2) Left out physicians who could earn high salaries through private sector practice
Contract with private sector physicians	Increase availability of private practice physicians to provide health services to national health insurance beneficiaries.	(1) Provided financial incentives to private sector physicians to work with the government to provide services and (2) Established lines of communication between the government and private providers	Limited the patient pool of private sector providers who did not contract with the government
Establish MoH-affiliated university hospitals	Introduce a new model of academic medicine allowing private medical universities to affiliated with MoH hospitals.	(1) Drew specialists and professors into MoH-run hospitals and (2) Provided political capital to AK Party politicians	Reduced authority of and drew resources away from well-established university hospitals and YÖK
Increase membership of health worker union aligned with AK Party	Build membership of and role in the health system of an organized physicians union that was closely aligned with the AK Party.	Established lines of communication between government and public sector physicians	Undermined authority and reduced membership of TMA

Source: Authors

Introduce pay-for-performance system

In 2004, the MoH introduced a performance-based supplementary payment system (PBSP) in public hospitals. This system was introduced to address issues of overcrowding, long waiting times, and low levels of patient and provider satisfaction with the health system that resulted from shortages of physicians, most of whom worked part-time and preferred private sector work (OECD, World Health Organization, and World Bank 2008). Under the PBSP system, public hospital physicians received their base salary from the MoH line item budget. The performance-based payments were paid from revolving funds that were financed primarily from social security

contributions. This financing split allowed the MoH to increase hospital physician salaries without having to alter general government civil service guidelines.

There were three components that determined a PBSP payment to a physician. First, each hospital chose how much of its revenues to allocate to the pool of PBSP payments. Second, this amount was adjusted based on an institutional performance score that the MoH determined for each hospital. The motivation behind this second component was to balance physician induced-demand with incentives for institutional quality (I-29). Third, each hospital's management determined individual performance scores for each of its physicians based on the number of procedures carried out, each of which received its own point level. This total point score was then adjusted by job title coefficient, the number of days a person had worked in a year, and whether the person was employed full-time or part-time in the hospital. The coefficient for full-time status was 1.0 and part-time was 0.4 (OECD, World Health Organization, and World Bank 2008).

Dividing Strategies: The PBSP system provided clear financial incentives for public sector physicians to work full-time in the public sector. Minister Akdağ referred to the PBSP system as the “carrot” needed to entice public sector physicians to give up their private practices (I-5). One key informant reported that for most MoH physicians the PBSP payments were so large that they could earn 70 percent more in the public sector than in the private sector (I-28). Another interviewee reported that as head of a hospital his salary tripled after the system was implemented (I-15). The prospect of having these performance payments reduced by 60 percent helped to persuade approximately 94 percent of MoH physicians to work full-time in the public sector by 2010 (I-28, I-13, I-17, I-9). Minister Akdağ put into place an extensive monitoring and enforcement system to ensure that physicians claiming to work full-time in the public sector

actually were doing so. He referred to this system as the “stick” in the system and could lead to firing if a physician were caught seeing private patients (I-5).

This action served to separate the financial interests of MoH physicians from those of university physicians working in highly-specialized tertiary care facilities who could earn high salaries in the private sector. These physicians, along with the TMA, were opposed to the PBSP system and argued that physicians were still not paid enough. They believed strongly that performance based payments should be part of the base salary, and not considered a bonus (Tanik 2014, I-15, I-14). Other interviewees argued that performance payment should not comprise the majority of physicians’ take home pay (I-14, I-16). This rationale was particularly important for pension payments that were only calculated on the base salary without the performance payments.

University physicians were particularly disadvantaged by the PBSP system because of the metrics used to determine performance payments. Time spent on teaching and publishing were not incorporated into the performance measures. Therefore, university professors were only awarded performance points for service delivery-related activities, which comprised only a portion of their job responsibilities (I-16, I-9, I-7). The TMA was also concerned that this system would introduce greater competition amongst physicians, which could erode teamwork in treating patients (Güven-Uslu and Yasar 2011). It also argued that the PBSP system would disincentivize physicians working in tertiary hospitals to treat complex patients as a result of the way the performance payments were calculated (I-14).

Contract with private sector physicians

The national health insurance system that was introduced as part of the HTP included the active involvement of the private sector through contracting arrangements. In 2003, the MoH began contracting with physicians to provide services in remote and underserved areas of the

country (Bump et al. 2015). These contractual assignments did not provide for the full rights associated with civil service, such as pension benefits and job security. As of 2008, the Social Security Institution, which was responsible for providing insurance coverage for the majority of Turkish citizens, contracted with approximately 1,000 private providers, 350 of which were private hospitals (OECD, World Health Organization, and World Bank 2008). These private sector providers and hospitals were reimbursed according to a negotiated fee schedule by the Social Security Institution. They could then charge their patients out-of-pocket for up to 90 percent of the Social Security Institution reimbursement level (I-13).

Dividing strategies: Contracting was a way for Minister Akdağ to provide financial incentives to private sector physicians to cooperate with MoH reform plans. While the PBSP system primarily targeted the interests of physicians working in the public sector, Minister Akdağ was also concerned about the potential for private sector physicians, to block his reforms through their power and influence in the health system. The proportion of physicians practicing in the private sector was relatively small as compared to that of public sector physicians (Table 3.1). However, due to absolute shortages of physicians in the country, the MoH needed to rely on both private and public sector resources to achieve the HTP policy objectives (Savas, Karahan, and Saka 2002). Contracting provided a way to integrate physicians who chose to stay in the private sector when the dual practice ban was put into place. It also served to further isolate physicians who chose to remain disengaged from the newly created national health insurance scheme by limiting their pool of patients.

In general, the AK Party pursued actions that involved the private sector in its reform plans (I-26, I-10, I-17). As representative of this broader reform approach, contracting served to create vital lines of communication between the MoH/Social Security Institution and private sector

physicians. This was particularly important because all private sector physicians were required to be members of the TMA, an organization that remained in staunch opposition to the ban on dual practice. These communication channels allowed Minister Akdağ to present his own reform message to private sector providers and also served to draw support away from the TMA.

Establish MoH-affiliated university hospitals

In 2008, the MoH began constructing new hospitals and provided incentives for medical universities to affiliate with these newly constructed hospitals. This policy was part of the MoH's efforts to expand training capacity in the country. This system was initially adopted in provinces where there was an identified need to expand training and hospital capacities (I-14). However, it was subsequently expanded to Istanbul (Marmara University) and Ankara (Yıldırım Beyazıt University). Minister Akdağ set out to create a new model for physician training where the MoH delivered services and universities provided training (I-5). This differed from the established model, where YÖK managed and controlled both service delivery and training activities in university hospitals.

Dividing strategies: Constructing and funding MoH-affiliated teaching hospitals served two purposes. First, it provided incentives for some university physicians to work in the newer hospitals with better resources. These incentives allowed Akdağ and his team to gain support from a cohort of highly skilled physicians who benefitted from working in the newer facilities. The construction of these new hospitals also provided important political capital to AK Party leaders, as interviewees reported that these hospitals tended to be built in areas that were geographically aligned with the AK Party (I-9, I-10).

Second, this policy served to draw resources away from the elite, university hospitals, which were the premier facilities in the country with respect to both training and service delivery.

As discussed above, these universities remained the nucleus of opposition to Minister Akdağ's plans to ban dual practice and to the HTP agenda in general. By presenting a viable alternative to the well-established university hospitals, Akdağ was able to reduce their power in the health system. YÖK, an organization known to be led by people opposed to the AK Party, no longer had a monopoly over specialized, tertiary care. Due to diminished resources in university hospitals, many physicians were driven towards MoH facilities or into private practice (Canca 2013, I-10, I-9, I-7). The AK Party was then able to replace these open physician positions with physicians who were more inclined to support its political and policy agenda. Interviewees reported that medical education also suffered as a result of the departure of university professors to the private sector who were no longer available to train students (I-7, I-16). Coupled with this departure, tertiary care centers did not receive their customary allocation of assistant professors because those physicians were assigned to public hospitals in service delivery roles.

Increase membership of health worker union aligned with AK Party

Although the TMA was the official professional association representing physicians in the country, there were two additional trade unions to which physicians could affiliate: Sağlık-Is under Turk-Is for private sector workers, and Sağlık-Sen under Memur-Sen for public sector workers. Unlike the TMA, these unions had collective bargaining rights (Sağlık-Sen 2013). Other cadres of health workers, including nurses and medical assistants, could also join these unions. Prior to the 2002 elections, Sağlık-Sen and its umbrella organization Memur-Sen were relatively small and did not have a large voice in the health system. However, this changed quickly after the AK Party came into office due to Memur-Sen's close ties with the party and its religiously inspired message. Memur-Sen's membership increased dramatically, growing from approximately 175,000 in 2002 to more than 400,000 in 2010 (Industrial Relations in Turkey 2013, I-37, I-14).

Sağlık-Sen's role representing the interests of public sector physicians increased as the TMA's advisory role decreased, once the AK Party was in office. Top level bureaucrats in the MoH were close friends with leaders of the Sağlık-Sen, and its members were an important source of support for Minister Akdağ's policies (I-14). The president of Sağlık-Sen from 2008 to 2011 was even elected to Parliament as a representative of the AK Party in 2011(Kaçar 2011).

Dividing strategies: The increased profile of Sağlık-Sen provided Minister Akdağ with a critical mechanism to delegitimize the authority of the TMA and reduce its power in the health system. Importantly, Sağlık-Sen was only comprised of public sector physicians, which was the group that would be directly affected by the ban on dual practice. As a result, the TMA was seen to represent private sector interests and those physicians that were opposed to the AK Party (I-24). The emerging power of this union presented an alternative to the TMA, and as a result drew health workers with religious leanings away from the TMA (I-17, I-24). As discussed above, the TMA held strong secular beliefs and was aligned with political parties in opposition to the AK Party (I-14, I-16, I-17). Therefore, Minister Akdağ and AK Party leaders were able to portray the TMA as representative of more radical and elitist views that were out of touch with the day-to-day realities of practicing medicine for most physicians in Turkey. Physicians affiliated with Sağlık -Sen could feel that the MoH, and AK Party in general, were better stewards of their interests in the health system as compared to the TMA (I-17, I-57).

The official position of Sağlık-Sen was to support the AK Party (I-17, I-57). Although it voiced concerns over some of the HTP policies, Sağlık-Sen was not seen as an opposition group to the ban on dual practice. The close affiliation between Sağlık-Sen and the AK Party provided a direct line of communication between Minister Akdağ and its members. Conversely, the TMA refused to engage in policy dialogue with Minister Akdağ and his team because they felt that

discussion was purely for show and not an effort to incorporate their feedback into policy proposals (Atun et al. 2013, I-14, I-5, I-17). This lack of communication further alienated the TMA and allowed the MoH to portray its leaders as unwilling to contribute to the health system transformation process on behalf of its members.

This action is representative of the general approach the AK Party has taken to dealing with interest group opposition. Similar to the TMA, the Turkish Industry and Business Association (TÜSİAD), which primarily represents large and well-established businesses in Turkey, has been in opposition to the AK Party due to concerns over the Party's Islamic-orientation (Öniş 2004). As a result, the AK Party has worked to diminish TÜSİAD's power and influence by increasing the prominence of the Independent Industrialists' and Businessmen's Association (MÜSİAD) (Sönmez 2014). MÜSİAD's membership is primarily comprised of small- and medium-sized businesses, and like Sağlık-Sen, it has an Islamist orientation in its policies and close ties with the AK Party. Instead of trying to work directly with opposition interest groups, the AK Party's has relied on new organizations, such as Sağlık-Sen and MÜSİAD, to reduce the potential veto power of secular elites in Turkey.

Discussion

The analysis in this case study has argued that Minister Akdağ and his team within the MoH deliberately took actions that divided physicians in order to create a favorable political environment for introducing and adopting the official ban on dual practice in 2010. The primary goal for this strategy of “divide and then conquer” was to create a sufficient supply of physicians who could meet growing patient demand for health services. It also served to reduce the power and influence of the TMA and its base of elite, university physicians. Given their political and ideological differences, Minister Akdağ and his team were unlikely to gain the support of these

opposition groups. In short, this divide and then conquer strategy drew power away from the TMA so that it could not act as a veto player to the ban on dual practice.

This analysis shows that Minister Akdağ and his team used a variety of different types of actions to divide physicians by exploiting their internal divisions (I-17). Similar to Posner, Spier and Vermeuele's (2010) model, these actions can be grouped according to those that provided incentives, disadvantaged or threatened, and created channels of communication to reduce resistance from some physicians and isolate physicians remaining in staunch opposition to the HTP and the AK Party in general. The four actions identified in this analysis served multiple political functions in dividing physicians, as discussed below.

First, Minister Akdağ and his team *provided incentives* for individual physicians to either support or remain neutral to their policy agenda through both financial and non-financial means. The PBSP and contracting actions provided clear financial incentives to both MoH and private sector physicians to cooperate with the MoH. The cooperation induced by the PBSP system meant that a majority of MoH physicians voluntarily gave up their private practices before the ban was even put into place. Importantly, these actions also circumvented stringent civil service regulations with respect to hiring and salaries. This flexibility gave Minister Akdağ and his team discretion over how physicians were paid and employed. They could also choose which physicians to target with these incentives to meet their policy objectives, which were focused on improving service availability in underserved areas of the country. These incentives spoke to the short-term financial interests of physicians because they were not factored into future pension payments. Minister Akdağ's actions also provided important non-financial interests to cooperate with the MoH. The newly constructed and better resourced MoH hospitals were an enticement for hospital physicians to leave the older, elite university hospitals that were centers of opposition to the AK Party and

run by YÖK. There were also benefits drawn from affiliating with Sağlık-Sen, given its increased influence and power in the health system due to its alignment with the AK Party and MoH leaders.

Second, the position of physicians remaining in opposition to MoH policies and the AK Party in general were explicitly *threatened or placed at a disadvantage* in the health system. The threats and disincentives to remain in opposition served to entice greater cooperation with the MoH amongst some physicians and further delegitimized and isolated others. Similar to the approach to incentives, Akdağ and his team used a combination of both financial and non-financial threats. The PBSP system generally disadvantaged any public sector physicians who continued to have private practice. But more explicitly, it targeted university physicians in its point system. University physicians in elite academic institutions were not only at a financial disadvantage under these actions, but they were also at a disadvantage with respect to service delivery capacity in areas where the new MoH hospitals were built. These actions to disadvantage and threaten the power of university physicians were targeted at their individual interests, as well as at the TMA as a professional association. Minister Akdağ presented Sağlık-Sen as an alternative organization that could represent the general interests of physicians in Turkey, unlike the TMA leaders who were presented as radical leftists (I-18, I-37). By drawing members away from the TMA, Minister Akdağ threatened its very existence as it relied entirely on membership contributions to finance its efforts.

Third, actions *created communication channels* to form divisions amongst physicians with respect to their position on the ban on dual practice. Contracting provided an important channel to integrate private sector physicians into the national health insurance delivery system. All private physicians received messages from the TMA. However, by contracting these physicians the Minister now had a direct way to communicate reform messages to them. Minister Akdağ and his

team also directly communicated with physicians working in the newly established MoH teaching hospitals and those that were affiliated with Sağlık-Sen, due their close ties with MoH leaders. These two actions also served the function of limiting the ability of YÖK and the TMA to communicate their opposition messages to some groups of physicians.

Minister Akdağ's strategic approach to dividing the MoH and some private sector physicians from university physicians and the TMA is representative of his general approach to the adoption and implementation of the HTP. He was primarily focused on banning dual practice as a means to improve the capacity of health service delivery for Turkish citizens. However, his actions also served to undermine the authority of critical opposition actors to the HTP and AK Party in general. This combination of improved service delivery and diminished power of the TMA and university physicians provided the necessary political capital to formally adopt the ban on dual practice in 2010. AK Party legislators could be assured that public sector services would be readily available to their constituents even after the ban was put into place. These legislators were also not threatened by the potential for political retribution from the TMA and university physicians due to their reduced stature in society.

While this approach served Minister Akdağ's goals of banning dual practice to increase service availability, it was not without costs both legislatively and to the health system in general. University physicians proved to be a powerful group, and Akdağ's inability to gain their support led to concessions due to their Constitutional Court challenge of the Law on Full Time Practice. By allowing university physicians to see patients in private sector offices after 5 pm, the Constitutional Court left the door open for further legislative actions, as well as ways for these physicians to find informal channels to continue dual practice (I-32, I-16, I-14, I-31, I-24). After Minister Akdağ left office, a move which has even been partially attributed to his antagonizing

university physicians and the TMA, the newly appointed Minister of Health Mehmet Müezzinoğlu (January 2013 -) granted additional exceptions for university physicians to engage in dual practice. A law passed in January 2014 allowed university physicians to treat patients in their private practices after 5 pm and also in university hospitals during regular working hours; however, they would have to give 50 percent of their private sector revenues to their affiliated university hospital.

In addition to presenting limitations to the official ban on dual practice, Minister Akdağ's efforts to isolate university professors and the TMA had consequences for health service delivery. By driving highly specialized and skilled physicians out of public sector practice, interviewees reported that the capacity and quality of tertiary care facilities and training institutions were diminished (Raufoglu 2013, I-8, I-16, I-14). There has even been a reported increase in violence against health workers since the start of the HTP, which interviewees attributed partially to Minister Akdağ's efforts to undermine the authority of health workers (Ayranci 2005, Boz et al. 2006, Zaman 2013, I-10, I-31, I-1).

The tradeoffs for the Turkish health system of this divide and then conquer strategy are reflected in the broader social implications of the AK Party's use of this strategy in general. As demonstrated by AK Party leaders' approach to the TMA and TÜSİAD, to achieve their policy objectives they systematically worked to undermine the authority and influence of opposition groups. While this approach has facilitated policy adoption, it has also served to polarize society in Turkey with bitter divisions, particularly between secular and Islamist forces in the country (Demiralp 2009, Heper 2003). These actions have raised concerns over potentially adverse consequences for democracy and citizens' rights in Turkey under the AK Party regime, particularly in light of the 2013 Gezi Park demonstrations in which physicians were barred from, and in some cases physically accosted for, administering emergency medical care to injured protestors

(Physicians for Human Rights 2013, Moudouros 2014). While the societal implications of the divide and then conquer reform approach are not the focus of this paper, they are important topics for future research.

Limitations

This study has limitations. As a single case study, this analysis cannot be extended to argue that a divide and then conquer strategy will be able to overcome medical association resistance to reform in all countries. Even within Turkey, Minister Akdağ and his team's efforts were greatly facilitated by the political and economic climates, the relatively limited powers granted to the TMA under Turkish law, and how Minister Akdağ's approach was replicated across other sectors in Turkey and in politics generally, among other factors. By using Posner, Spier and Vermeuele's conceptual framework, we make a theory-based argument for how Akdağ's actions divided physicians and how this division contributed to the ban on dual practice. We also only present a limited discussion of the tradeoffs associated with Minister Akdağ's, and the AK Party's more broadly, strategic approach to reform, without undertaking a full analysis.

In addition to this general limitation of the case study method, this study is also constrained by the choice of interviewees. We were only able to elicit feedback from a subset of the myriad of potential stakeholders in the health reform process, and the interviewees were focused in the urban centers of Ankara and Istanbul. We made generalizations of physicians' positions and interests in the reform process, which may not accurately reflect the views of all members of those physicians groups. Our account is also limited by recall bias because it concerns events well in the past.

Conclusions

This paper shows how carefully constructed actions can serve dual objectives in a health reform. First, they can have important consequences for health service delivery goals. By appealing to the financial and non-financial interests of individual MoH and private sector physicians, Minister Akdağ was able to strengthen delivery capacity by retaining health workers to provide services in the public sector after putting in place the ban on dual practice. Second, actions can serve political functions by disadvantaging groups opposed to reform. Minister Akdağ sought to reduce the power of the TMA and elite university physicians because they were known opposition groups to the HTP and AK Party in general. As a result, he worked to divide their interests from other physicians and diminish their political influence. Rather than entering into direct negotiations with groups opposed to the reform, Minister Akdağ used his authority as Minister of Health to introduce concrete actions and policies that facilitated the achievement of his policy objectives. These strategies created important cleavages between physicians with different preferences in the health reform process that proved to be critical to passing the ban on dual practice while increasing service delivery capacity.

This analysis of Minister Akdağ's strategy to adopt the ban on dual practice provides a significant contribution to the literature on health reform. It also gives policymakers in other countries critical insight into a potential strategic approach to managing physicians in a reform process and the importance of weighing tradeoffs associated with any reform strategy. As the Turkish case demonstrates, policymakers will continue to grapple with the consequences of these tradeoffs even after a reform policy has been adopted.

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CHAPTER 4: EFFECT OF PRIMARY HEALTH CARE REFORMS ON USER SATISFACTION: EVIDENCE FROM TURKEY

Introduction

Improved levels and distributions of health, financial risk protection and patient satisfaction are usually considered to be three primary goals health systems should strive to achieve (World Health Organization 2000, Roberts et al. 2004). While population health outcomes and financial risk protection are objective measures, patient satisfaction relies on subjective assessments of the health system by patients, reflecting the perceived fulfillment of their needs and desires through the use of healthcare services (Chimbindi, Bärnighausen, and Newell 2014).

How satisfied patients are with their health systems is important to policymakers for at least three major reasons. First, at a fundamental level, policymakers should want to maximize the overall happiness or utility patients derive from their health care seeking experience. As such, patient satisfaction can be thought of as patients' judgment on the quality of care provided and is equally as important as more objective measures of quality (Pascoe 1983, Donabedian 1976). Second, beyond this intrinsic motivation, improving patient satisfaction can serve an instrumental function by increasing retention in care and adherence to medication and health workers' advice (Roberts 2002, Peltzer 2009). Third, patients are the electorate in a political system and their dissatisfaction with the health system can contribute to regime change (Roberts et al. 2004).

Patient satisfaction is particularly central to assessing the performance of primary health care (PHC), where preventive services and most of the care for chronic illness is delivered (World Health Organization 2008). As the first point of contact for citizens in a health system, it is critical to understand "citizens' expectations about health and health care" to ensure "that their voice and

choice decisively influence the way in which health services are designed and operated”(World Health Organization 1996). The 2008 World Health Report stresses the importance of patients by calling for a renewed focus on PHC which “puts people at the center of health care” (World Health Organization 2008).

Despite the importance of patient satisfaction as a health system goal, there are no studies that have established the causal effects of health systems changes and reform on patient satisfaction. Rather, research on patient satisfaction has correlated different types of health systems or socio-demographic characteristics with varying levels of patient satisfaction (Bjertnaes et al. 2011, Penchansky and Thomas 1981, Thomas and Penchansky 1984, Hjortdahl and Laerum 1992, Atkinson and Haran 2005, Baker and Streatfield 1995, Becker, Drachman, and Kirscht 1974, Fox and Storms 1981, Hekkert et al. 2009, Çetin et al. 2012, Young, Meterko, and Desai 2000, Kersnik 2000, Chimbindi, Bärnighausen, and Newell 2014, Wensing, Mainz, and Grol 2000, Bleich, Özaltın, and Murray 2009, Grol et al. 2000, Xesfingi and Vozikis 2014). These studies cannot establish causal effects of health systems reform on patient satisfaction levels.

In this study, we establish for the first time the causal effect of a major health system reform – introduction of the so-called family medicine-centered PHC in Turkey – on patient satisfaction, applying a quasi-experimental approach to data from Turkey. The introduction of family medicine-centered PHC was part of Turkey’s broader Health Transformation Program (2003-2012). Unlike the other elements of this national health reform, the family medicine-centred PHC was introduced sequentially over time across the 81 provinces in Turkey. It was intended to improve patient satisfaction and public perception of the quality of PHC services. Low patient satisfaction and widespread perception that the PHC services were of poor quality had led patients to bypass PHC facilities to go directly to hospitals, even for routine and basic care (World Bank 2013). We exploit

the sequential introduction of the family medicine-centered PHC across provinces between 2010 and 2012 to establish whether this transformation of the Turkish PHC system achieved its objective of improving patient satisfaction. We apply a province-level fixed effects analysis to provincially-representative patient exit survey data from the Turkish Patient Satisfaction with Health Service Survey (TPSHSS), which was carried out in 2010, 2011, and 2012.

Primary health care reform in Turkey, 2005 - 2012

While Ministry of Health leaders intended to address a range of shortcomings in PHC in Turkey through the Health Transformation Program and family medicine-centered PHC, from the beginning one of the main motivations for the reform was to improve patient satisfaction (Atun et al. 2013). In 2003, only 40% of the Turkish population indicated that they were satisfied with the quality of care, as compared to 48% in Greece, 55% in Spain, and 84% in France (Bleich, Özaltın, and Murray 2009, OECD, World Health Organization, and World Bank 2008). As a result, Turkish policymakers identified improvements in PHC as critical to improving overall citizen satisfaction with the Turkish health system (Ministry of Health of the Republic of Turkey December 2003). PHC in Turkey was underfunded relative to secondary and tertiary care, and consequently facilities lacked adequate human and operational resources, as well as necessary equipment and supplies (Savas, Karahan, and Saka 2002, Akdağ 2011). As a result, PHC was plagued by long waiting times and poor quality, despite overall low levels of PHC utilization (OECD, World Health Organization, and World Bank 2008).

Family medicine-centered PHC was piloted in Düzce province in 2005 and following successful evaluation (see Atun et al. 2013), was subsequently rolled out nationwide by 2011. The introduction of family medicine-centered PHC set out improve patients' perception of PHC in Turkey through five specific policy interventions.

First, to accomplish this transformation, the Ministry of Health dedicated additional financial resources to PHC. Between 2002 and 2007 alone, expenditures on PHC and preventive services tripled (OECD, World Health Organization, and World Bank 2008). Second, the Ministry of Health created a new designation for general practitioners by requiring an additional ten-day training program in family medicine. Upon completion of this training, these physicians were categorized as family medicine specialists. Third, these newly trained family medicine specialists were then hired on two-year performance-based capitated contracts that linked their salary to three maternal and child health performance indicators, as well as 35 service delivery performance indicators and targets (Akdağ 2011). Under this system, base salaries of family medicine specialists could be reduced by 20% if they failed to meet performance targets and they could lose their contracts if they did not keep their enrolled patient list above 1,000 (Johansen and Guisset 2012, Akdağ 2011). Fourth, every Turkish citizen was enrolled as a patient of a specific family medicine specialist. Patients could select their family medicine specialist, and if they didn't exercise their choice, they would be assigned. As a result, there were incentives for family medicine specialists to both attract patients to maintain a sufficient enrolled patient list and also ensure that patients did not select a different physician. Fifth, the Ministry of Health increased the number of Ministry of Health-affiliated PHC facilities, with a particular focus on underserved areas of the country. The number of PHC facilities more than tripled between 2002 and 2012, growing from 9,094 in 2002 to 36,474 in 2012. Of these new PHC facilities, 57% were contracted family medicine centers that provided free of charge, preventive and community health care services, as well as maternal and reproductive health services (Republic of Turkey Ministry of Health 2013).

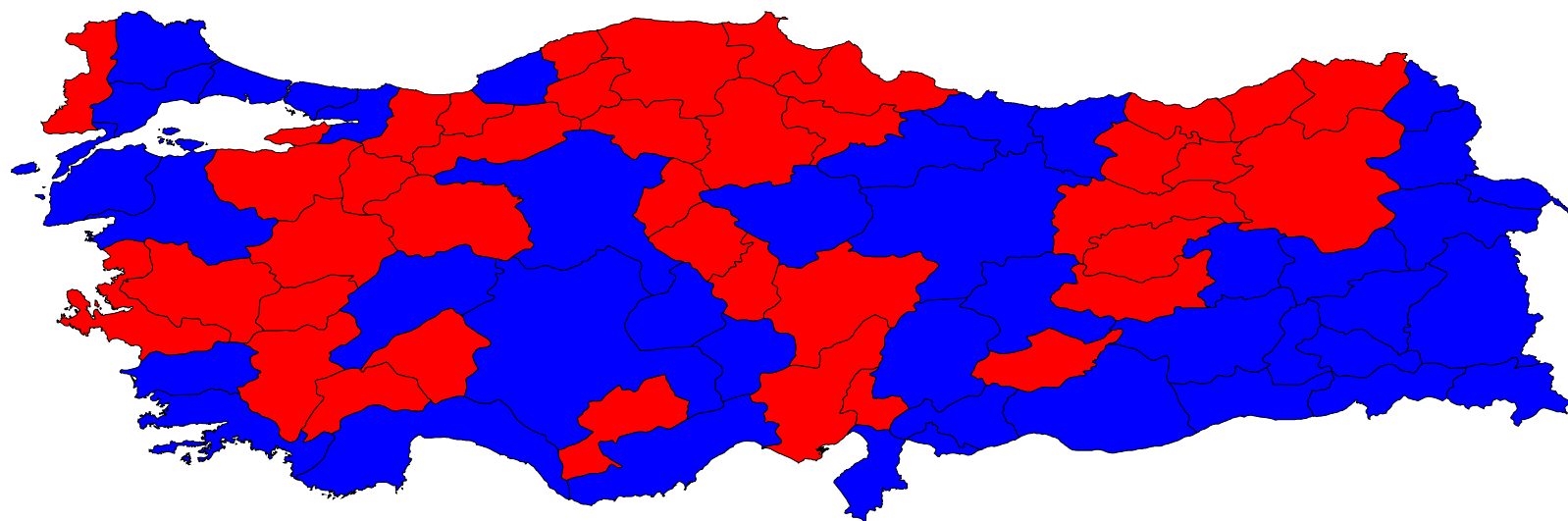
In this paper, we examine whether the combination of these five policy changes that were part of family medicine-centered PHC in Turkey, which expanded the PHC workforce and delivery system and introduced incentives to motivate physician behavior led to improved patient satisfaction.

Data and Methods

Intervention exposure

As of December 2009 (TPSHSS 2010), 40 of Turkey's 81 provinces had fully implemented the family medicine-centered PHC and the remaining 41 provinces introduced it after December 2009 (Figure 4.1). By December 2010 (TPSHSS 2011 and 2012) all 81 provinces in Turkey had fully implemented the family medicine-centered PHC (Figure 4.1). The Ministry of Health considered full implementation of the family medicine-centered PHC to take six months. Of the 41 provinces that introduced the family medicine-centered PHC after December 2009, 8 provinces began introducing it between December 2009 and June 2010, when the baseline survey data was collected (5 provinces in January 2010, 2 in April 2010, and 1 in May 2010) (World Bank 2013).

Figure 4.1: Intervention and Control Provinces



Legend
Intervention provinces
Control provinces

Source: TPHSS 2010, 2011, and 2012

The 41 intervention provinces had not established family- medicine-centered PHC in 2010, but had established it in 2011 and 2012. The 40 control provinces had already established family-medicine-centered PHC in 2010.

Intervention provinces: İzmir Adana, Adıyaman, Amasya, Artvin, Bartın, Bayburt, Bilecik, Bolu, Burdur, Bursa, Çankırı, Çorum, Denizli, Düzce, Edirne, Elazığ, Erzincan, Erzurum, Eskişehir, Gümüşhane, Isparta, Karabük, Karaman, Kastamonu, Kayseri, Kırşehir, Kırıkkale, Kütahya, Manisa, Nevşehir, Osmaniye, Rize, Sinop, Sakarya, Samsun, Trabzon, Tunceli, Uşak, Yalova.

Control provinces: Şanlıurfa, Şırnak, İstanbul, Afyonkarahisar, Ağrı, Aksaray, Ankara, Antalya, Ardahan, Aydın, Bitlis, Balıkesir, Batman, Bingöl, Giresun, Gaziantep, Çanakkale, Diyarbakır, Hakkâri, Hatay, Iğdır, Kilis, Kahramanmaraş, Kars, Kırklareli, Kocaeli, Konya, Malatya, Mardin, Mersin, Muş, Muğla, Niğde, Ordu, Siirt, Sivas, Tekirdağ, Tokat, Van, Yozgat, Zonguldak.

Outcomes data and variables

The outcomes data for this analysis were taken from three provincially-representative TPSHSS 2010, 2011, and 2012. These three cross-sectional surveys were based on the European Patients Evaluate General/Family Practice (EUROPEP) Patient Satisfaction Scale, which consists of 23 standard and internationally comparable questions asking patients to make assessments of general practice care (see Table 4.1 for individual questions) (Mollahaliloglu et al. 2010). The EUROPEP scale was developed in 1999 by the European Working Party on Quality in Family Practice (EQUIP), a sub-unit of the European Office of the World Organization of Family Doctors (WONCA) and has been used in 25 European countries to date (Mollahaliloglu et al. 2010). The TPSHSS was representative both at the national level and the provincial level. For this patient exit interview survey, clinic-days were randomly sampled from a sampling frame of all PHC clinics in all 81 Turkish provinces in each of the three years 2010, 2011, and 2012. Patients were sampled randomly within clinic-days. The data were generated by individual-level cross-sectional surveys, where the individuals we randomly sampled for participation (Deaton 1985).

The outcome variables for our analysis were taken from the 23 TPSHSS questions. We carried out two types of statistical analysis. First, we treated each of the 23 survey question as a separate outcome variable. The responses for satisfaction outcomes were categorical and were coded on a five-point Likert scale: “very bad/very dissatisfied” (1), “bad/dissatisfied” (2), “neither/neutral” (3), “good/satisfied” (4), and “very good/very satisfied” (5).

Second, we conducted a principal component analysis to identify principal components of PHC across the 23 questions (Wensing, Mainz, and Grol 2000). This procedure took the 23 outcome variables across all three survey years and created uncorrelated principal components, where each principal component was a linear weighted combination of the initial variables (see

Appendix 4.1) (Vyas and Kumaranayake 2006). The use of principal component analysis to reduce a large set of Likert-scale-based patient satisfaction variables into a few principal components is a common approach, because it focuses the analysis on a few fundamental dimensions of patient satisfaction that generate the patient satisfaction data (Ware and Snyder 1975, Pascoe 1983, Roberts, Pascoe, and Attkisson 1983, Ware Jr et al. 1983, Linder-Pelz 1982, Thomas and Penchansky 1984). However, unlike the individual patient satisfaction variables, the principal component scores did not have a natural meaning. To allow the interpretation of results in terms of each of the individual patient satisfaction outcomes as well as the few underlying dimensions of patient satisfaction, we used both the individual satisfaction outcomes and the principal components to quantify the causal effects of the introduction of family medicine-centered PHC in Turkey.

We used an orthogonal (varimax) rotation in the principal component analysis. To identify the principal components for use as outcome variables in our causal analyses, we used the Kaiser criterion selecting principal components with eigenvalues of 1.0 or higher (Jeffers 1967).

Causal analysis

The staggered introduction of family medicine-centered PHC across Turkish provinces allowed province-level fixed effects analysis to evaluate the causal effect of the introduction of family medicine-centered PHC on patient satisfaction in Turkey (Imbens and Wooldridge 2009, Wooldridge 2010, Rockers et al. 2015). The changes over time in outcomes in the “intervention provinces” from before (in 2010) to after (in 2011 and 2012) family medicine-centered PHC was implemented was contrasted to the change in outcomes over the same time period in the “control provinces”, in which family medicine-centered PHC was consistently implemented throughout the

entire period of observation (Figure 4.1). This contrast generates the province-level fixed effect estimate of the causal effect of the family medicine-centered PHC on patient satisfaction.

All models were estimated using the statistical software package, Stata 13.0 (StataCorp 2014). We used an ordered-logit model to estimate the results for the 23 individual estimations (analysis 1) because the outcome variables are all ordered categorical data (Dobson and Barnett 2008). We use province-level fixed effects for causal inference. The ordered-logit approach provided a single estimate for the coefficient that describes the relationship between intervention and satisfaction ratings for each outcome variable and represented a weighted average of estimated odds ratios obtained from different ways of combining the outcome categories that preserved the natural ordering of the outcome variable (Winship and Mare 1984, Kleinbaum et al. 2008). For the second analysis, using principal components as outcome variables, we used ordinary least squares (OLS) models in the fixed effect estimation.

Control variables

The province-level fixed effects in our analysis controlled for confounding on all observed and unobserved province-level factors that were constant over the observation period, such as geographical location within Turkey or local culture (Sitzia 1999). Additionally, we controlled for potential time-varying confounders: Respondent's age, sex, education, and place of residence (rural versus urban). Age, sex and education have commonly been found to be important determinants of patient satisfaction in previous studies (Pascoe 1983, Hekkert et al. 2009). Finally, we controlled for secular trends in patient satisfaction through time fixed effects. All error terms were clustered at the provincial level.

Samples and sensitivity analyses

Of the total 101,903 TPSHSS survey respondents (34,472 respondents in 2010, 34,764 respondents in 2011, and 32,667 respondents in 2012), 32,875 did not answer one or more survey questions. We first conducted our analyses using the sample of respondents who answered all 23 patient satisfaction questions in the TPSHSS (69,028). This sample had the advantage of remaining the same when we used different satisfaction questions as outcome variables, ensuring that differences across the fixed effect estimations were entirely due to the different outcomes and not due to different samples. We also used this sample to carry out the principal component analysis, and the fixed effect estimation using the principal components representing the data.

To test the robustness of our findings, we carried out three additional analyses. First, we reran the estimations with the individual patient satisfaction variables as outcomes, using the largest possible sample without missing data for each particular patient satisfaction outcome. Second, we imputed all missing values using chained multiple imputations, and then reran all estimations with the individual patient satisfaction variables as outcomes (Royston and White 2011). The results of these two robustness checks are shown in the Appendix 4.2. Third, we reassigned the eight provinces that had partially introduced family medicine-centered PHC between January 2010 and May 2010 to the set of control provinces rather than to the set of intervention provinces. We found the effect sizes shown in Figure 2 and Table 2 remained essentially unchanged (all coefficients changed by no more than 5%) and none of the determination of significance changed.

Results

Descriptive statistics

Table 4.1 shows summary statistics of the independent variables for the survey population in 2010, 2011 and 2012 respectively. At baseline, average patient ratings in intervention provinces were between “neutral” (3) and “satisfied” (4) for eight indicators and between “satisfied” (4) and “very satisfied” (5) for 15 indicators (with a highest average rating of 4.2). Between 2010 and 2012, an increasing proportion of respondents gave high satisfaction ratings (“satisfied” or “very satisfied”) across all survey questions and for the estimated principal components.

Table 4.1: Summary Statistics for Independent Variables

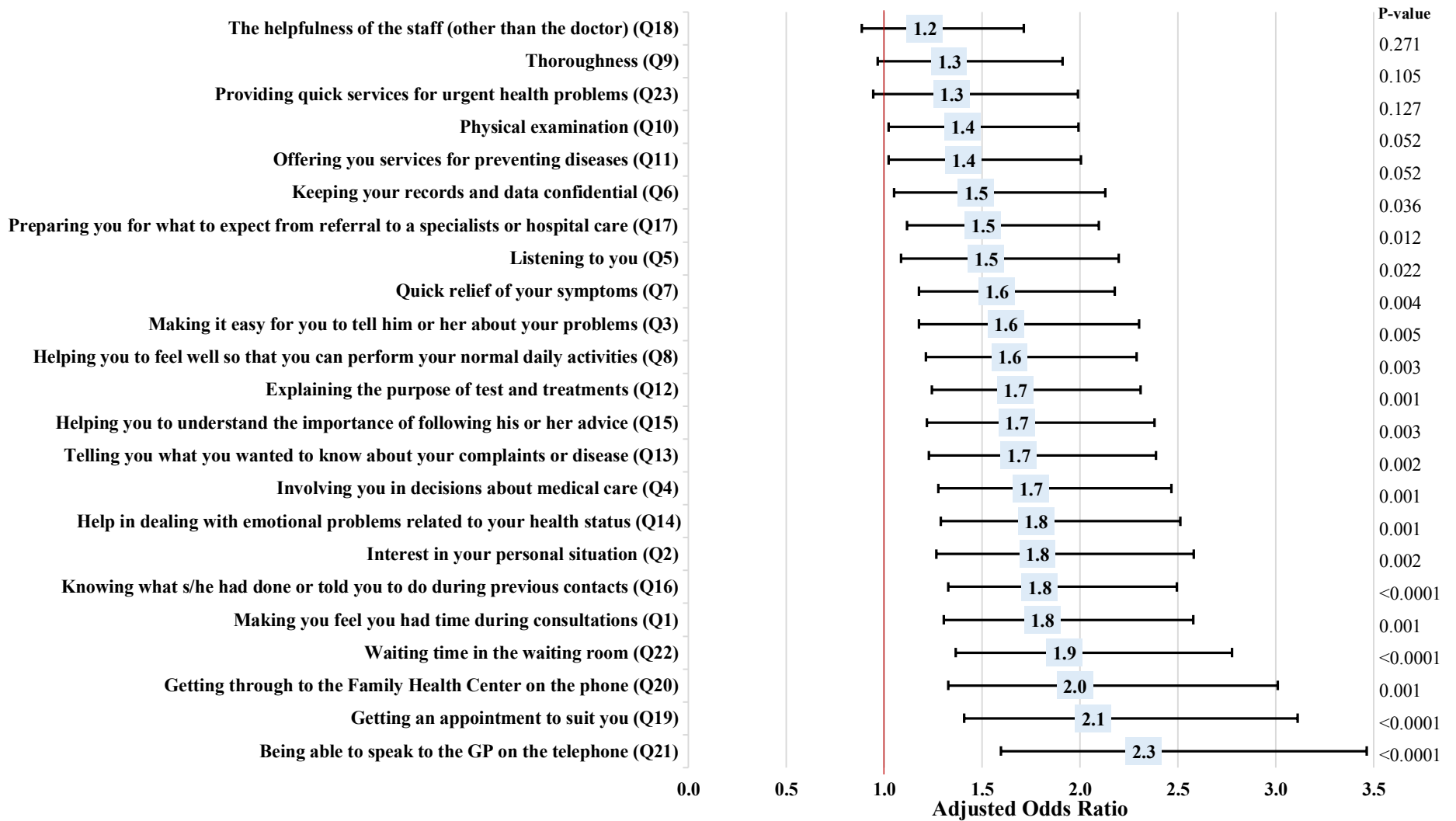
Variable	2010						2011		2012	
	Control Provinces*		Intervention Provinces*		All Provinces		All Provinces		All Provinces	
	Frequency (N)	Relative Frequency (%)	Frequency (N)	Relative Frequency (%)	Frequency (N)	Relative Frequency (%)	Frequency (N)	Relative Frequency (%)	Frequency (N)	Relative Frequency (%)
Sex										
Male	4,498	50.6	4,944	48.7	9,442	49.6	11,196	50.2	13,873	49.9
Female	4,388	49.48	5,210	51.1	9,598	50.4	11,090	49.8	13,906	50.1
Education										
Illiterate	713	8.0	1,070	10.5	1,783	9.4	1,938	8.7	2,499	9.0
Primary education	4,389	49.4	4,755	46.8	9,144	48.0	12,542	56.3	15,090	54.3
High school education	2,445	27.5	2,953	29.1	5,398	28.4	5,036	22.6	6,141	22.1
Bachelor/post-graduate education	1,339	15.1	1,376	13.6	2,715	14.3	2,770	12.4	4,049	14.6
Place of residence**										
Urban	6,251	69.9	6,135	60.4	12,350	64.9	20,828	93.5	24,807	89.3
Rural	2,671	30.1	4,019	39.6	6,690	35.1	1,458	6.5	2,972	10.7
Family medicine implemented										
No					10,154	53.3	0	0	0	0
Yes					8,886	46.7	22,286	100	27,779	100
	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Age	41.0	15.3	37.8	14.1	39.3	14.7	39.3	15.1	40.4	15.5
Socioeconomic Development Index***	12.3	6.1	16.7	7.5						

*Control represents all provinces that fully implemented family medicine-centered PHC and Intervention represents all provinces that had not fully implemented family medicine-centered PHC. **The classification for urban and rural was altered between 2010 and 2011/2012. In 2010, four categories were used to classify whether an individual resided in an urban or rural area. There is a difference in frequencies in 2010 as compared to 2011/2012 as a result of this discrepancy in classification. Sampling was consistent within years across the urban/rural categories and therefore we include it as a control variable. ***The socioeconomic development index uses ingredients analysis to develop a composite index by bringing together population-based representative survey data from 2009 and 2010 on 61 parameters grouped into eight categories, namely: demographic (five parameters); education (six); health (five); employment (eight); competitiveness and innovation capacity (15); fiscal capacity (seven); access (six); and life satisfaction (nine). Data are from The Republic of Turkey, Ministry of Development, Directorate General of Regional Development and Structural Adjustment; Monitoring, Evaluation, and Analysis Department, Level 2 zones, socioeconomic development ranking, May 1, 2013.

Fixed effect estimations: satisfaction questions

Figure 2 shows the results of the province-level fixed effects estimations using the 23 individual patient satisfaction questions as outcome variables. The introduction of family medicine-centered PHC had either a positive (18 questions) or insignificant (4 questions) effect on patient satisfaction (Figure 4.2). The adjusted odds ratios for the outcome variables with statistically significant results (p -values <0.05) ranged from 1.37 to 2.33, i.e. the introduction of family medicine-centered PHC increased patient satisfaction ratings on average by about one and half to two categories on the Likert scale of satisfaction categories. If we use a stricter threshold for significance due to multiple hypothesis testing (p -value <0.002), 9 of the 23 outcome variables have statistically significant results with coefficients ranging from 1.67 to 2.33 (Bland and Altman 1995).

Figure 4.2: Regression Results for Fixed Effect Estimations: Survey Questions



Adjusted odds ratios estimations control for time, education, sex, age, and place of residence. Standard errors are clustered at the province level. By carrying out 23 estimations, we increase the probability of falsely identifying a significant result. To control for this Type I error, we can use the Bonferroni adjustment for our p-values. By doing so, we would only judge results to be significant if the p-value is less than 0.002.

Results of the principal component analysis

The first two components identified in the principal component analysis had an eigenvalue greater than 1.0. Combined these two components explained 65% of the total variance in the patients satisfaction data (principal component 1 (PC1) explains 49% and principal component 2 (PC2) explains 16%). Variables that loaded heavily ($\geq 15\%$) on PC1 captured different aspects of satisfaction with health care workers' clinical behavior, such as "listening to you" and "physical examination" (survey questions 1 through 17). Variables that loaded heavily ($\geq 15\%$) on PC2 captured satisfaction with the processes and policies affected by the organization of care in PHC facilities operates, such as "getting an appointment to suit you" and "waiting times" (survey questions 17 through 23) (see Table 4.2 for factor loading results). These two dimensions of patient satisfaction are the same as those identified by the developers of the EUROPEP survey in an application across 16 European countries (Wensing, Mainz, and Grol 2000). As in this previous study, we thus interpret PC1 as a measure of patient satisfaction with clinical behavior and PC2 as a measure of patient satisfaction with the organization of care (Wensing, Mainz, and Grol 2000).

Table 4.2: Principal Component Factor Loading Results

Question	Outcome	PC1: Clinical Behavior	PC2: Organization of Care
Q1	Making you feel you had time during consultations	0.27	-0.05
Q2	Interest in your personal situation	0.27	-0.04
Q3	Making it easy for you to tell him or her about your problems	0.28	-0.07
Q4	Involving you in decisions about medical care	0.26	-0.04
Q5	Listening to you	0.29	-0.11
Q6	Keeping your records and data confidential	0.24	-0.05
Q7	Quick relief of your symptoms	0.25	-0.01
Q8	Helping you to feel well so that you can perform your normal daily activities	0.25	-0.01
Q9	Thoroughness	0.28	-0.07
Q10	Physical examination	0.27	-0.06
Q11	Offering you services for preventing diseases	0.20	0.06
Q12	Explaining the purpose of test and treatments	0.21	0.06
Q13	Telling you what you wanted to know about your complaints or disease	0.23	0.03
Q14	Help in dealing with emotional problems related to your health status	0.18	0.12
Q15	Helping you to understand the importance of following his or her advice	0.21	0.09
Q16	Knowing what s/he had done or told you to do during previous contacts	0.17	0.14
Q17	Preparing you for what to expect from referral to a specialists or hospital care	0.16	0.16
Q18	The helpfulness of the staff (other than the doctor)	0.09	0.23
Q19	Getting an appointment to suit you	0.04	0.36
Q20	Getting through to the Family Health Centre on the phone	-0.05	0.51
Q21	Being able to speak to the GP on the telephone	-0.05	0.50
Q22	Waiting time in the waiting room	0.03	0.35
Q23	Providing quick services for urgent health problems	0.09	0.27

Factor loadings >0.15 are shown in bold font. The principal component “Clinical Behavior” explains 49% of total variance, and the principal component “Organization of Care” explains 16% of total variance.

Fixed effect estimations: principal components of patient satisfaction

Table 4.3 presents the results of the province-level fixed effects estimations models using PC1 (satisfaction with clinical behavior) and PC2 (satisfaction with organization of care) as outcome variables. The results that included the time fixed effects were the more conservative estimates because they controlled for any variability related to time. In addition to controlling for the underlying secular trend, a portion of this variability may have been attributable to the fact that the causal effect of the introduction of family medicine-centered PHC may have increased over time because of improved implementation capacity and could therefore be considered as part of the causal effect. The coefficient results showed a positive and statistically significant effect (p -values < 0.05) of the introduction of family medicine-centered PHC on the outcome variables even

after controlling for time fixed effects. Similar to the results using the individual patient satisfaction responses as outcome variables, we found that the introduction of family medicine-centered PHC led to a significant increase in patient satisfaction with both clinical behavior (PC1) and the organization of care (PC2).

Table 4.3: Fixed effects Regression Results: Principal Components of Patient Satisfaction

Variable	Principal Component #1				Principal Component #2			
	Clinical Behavior (95% CI)	p-value	Clinical Behavior (95% CI)	p-value	Organization of Care (95% CI)	p-value	Organization of Care (95% CI)	p-value
Intervention	1.90 (1.40-2.1)	<0.0001	1.12 (0.47-1.77)	0.001	1.18 (0.83-1.52)	<0.0001	0.84 (0.41-1.27)	<0.0001
<i>Year*</i>								
2010	-	-	Ref.	Ref.	-	-	Ref.	Ref.
2011	-	-	0.49 (0.02-0.96)	0.04	-	-	0.06 (-0.24-0.37)	0.68
2012	-	-	1.04 (0.61-1.48)	<0.0001	-	-	0.55 (0.28-0.81)	<0.0001
<i>Sex</i>								
Male	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
Female	0.12 (0.06-0.19)	<0.0001	0.12 (0.05-0.18)	<0.0001	0.02 (-0.02-0.05)	0.38	0.01 (-0.02-0.05)	0.48
Age	0.01 (0.01-0.02)	<0.0001	0.01 (0.01-0.02)	<0.0001	0.01 (0.01-0.01)	<0.0001	0.01 (0.01-0.01)	<0.0001
<i>Place of residence</i>								
Urban	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
Rural	0.00 (-0.24-0.24)	0.998	0.08 (-0.16-0.31)	0.533	0.22 (0.06-0.37)	0.006	0.24 (0.09-0.37)	0.003
<i>Education</i>								
Illiterate	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
Primary education	0.13 (0.00-0.26)	0.052	0.10 (-0.02-0.23)	0.108	0.09 (0.01-0.17)	0.033	0.08 (-0.01-0.16)	0.05
High school education	-0.15 (-0.29-0.01)	0.040	-0.16 (-0.30-0.02)	0.030	-0.05 (-0.14-0.04)	0.282	-0.05 (-0.15-0.04)	0.24
Bachelor/post-graduate education	-0.15 (-0.33-0.03)	0.104	-0.18 (-0.35-0.00)	0.049	-0.02 (-0.14-0.10)	0.762	-0.04 (-0.15-0.08)	0.51
Province fixed effect	Y		Y		Y		Y	
Observations	69,028		69,028		69,028		69,028	

*We cannot determine if time fixed effects control only for an underlying secular trend or whether it also controls for some of the policy effect because introduction of family medicine-centered PHC was rolled out in two major steps. Due to the time needed for full implementation, some of the variability controlled for through the inclusion of time fixed effects may actually be attributable to the introduction of family medicine-centered PHC. Therefore, we consider our point estimates reported in Table 4.2 to be lower and upper bounds of the effect of the introduction family medicine-centered PHC on patient satisfaction ratings.

Discussion

Our results show that a major reform of a health system – the introduction of family medicine-centered PHC in Turkey – substantially improved patient satisfaction across a wide range of quality dimensions. These findings represent an important contribution to the literature because they are the first causally strong effect size estimates of the impact of a major national health system reform on patient satisfaction. How patients rate and respond to their health system is an important goal of health system reforms. Intrinsically, health systems must aim to satisfy the demands patients place on the quality of their care. Instrumentally, more satisfied patients are expected to be more likely to seek and adhere to needed treatment. The causal effect of policy changes on patient satisfaction is particularly critical in the PHC component of health system reforms given the recent focus on “people-centered” PHC, which requires health care providers to place the physical, emotional and social concerns at the centre of PHC delivery (World Health Organization 2008). Despite the fact that patient satisfaction is seen as a primary outcome of health systems alongside health improvement, strong causal evidence on the effects of changes to PHC on patient satisfaction had been hitherto lacking.

Our quasi-experimental approach demonstrates the power of community-level fixed effects analysis in answering important health system questions. The combination of the step-wise rollout of family medicine-centered PHC with repeated cross-sectional provincially-representative patient exit survey allowed us to conduct provincial-level fixed effects analysis to reach causal conclusions on the impact of the intervention on patient satisfaction. This approach to causal inference will be a powerful analytical strategy whenever national health systems reforms are introduced sequentially over time across different sub-national communities (e.g. provinces or districts).

In addition to this general contribution to the literature, our results are particularly important for Turkey's policymakers and citizens. The Ministry of Health's choice to focus on patient satisfaction as an important health systems goal and outcome measure for its health system reform carries with it important policy implications. By doing so, policymakers were able to substantially improve satisfaction with PHC services in Turkey, and as a result they translated the aspiration of "people-centered health systems" into practice through the introduction of family medicine-centered PHC.

These findings have implications beyond just the health system. From a political standpoint, gauging public opinion about specific aspects of health system reform that was widely discussed in public media can inform policymaking priorities and improve political standing for those concerned (Bump and Sparkes 2014). In the case of Turkey, the positive perception of the Health Transformation Program was an important factor in contributing to continued political support for the Turkish Adalet ve Kalkınma Partisi (AK Party), which spearheaded the reform effort (see Chapters 2 and 3). As Turkey enters its next phase of health system reform, it will have to maintain this focus on PHC while meeting its population's health care demands and needs. It is yet to be seen if the effect of the family medicine-centered PHC on patient satisfaction will last beyond the initial years of implementation.

Another way to use these results is to inform policymakers on how to change healthcare seeking behavior of patients. Thomas and Penchansky (1984) view access as the "degree of fit" between patient expectations and the health system. Patient satisfaction captures important dimensions of this "fit", and is a key link between access and actual utilization of care. To even better understand how this "fit" can be maintained, it will be useful to study the mechanisms linking the family medicine-centered PHC with satisfaction.

In this study, we evaluate the entire package of the family medicine-centered PHC changes and thus we cannot know which particular component of the entire package was responsible for increased patient satisfaction. It is plausible that improved health system capacity (financial and human resources) increased the availability of PHC resources and consequently population demands for health care were more likely to be met (Thomas and Penchansky 1984). Another plausible mechanism is that the performance-related contracts that were introduced with the family medicine-centered PHC reform physicians' motivation to thrive to better meet patient expectations. For instance, the performance-based contracts stipulated that physicians could lose up to 20% of their salary at the end of the year for failing to meet performance targets related to service delivery governance, measures of quality, and maternal and child health service coverage (World Bank 2013). Additionally, despite the lack of a formal gatekeeping function, family medicine specialists became directly accountable to and responsible for their enrolled patients. Family medicine specialists could want to satisfy their patients both to maintain their patient list to maximize capitation payments and remain above the contractual minimum of 1,000 patients. This patient-family medicine specialist assignment system also creates a direct relationship between patient and provider that could lead to increased satisfaction amongst patients due to improved continuity of care and personal interactions. Future research, including qualitative interviews with patients and health workers and participant observation, may elucidate further the mechanisms transmitting the effect of the introduction family medicine-centered PHC on patient satisfaction.

Limitations

There are several important limitations to our analysis. First, we are unable to perfectly control for patient need in our analysis. Treatment need could theoretically have confounded our

findings, e.g., if need were reduced in lock-step with program implementation. However, major changes in treatment need over a three year period and on a national scale are unlikely, and, to a large extent, need will have been captured by our time-varying individual-level control variables, including sex, age and education (Breyer, Heineck, and Lorenz 2003). Second, the TPSHSS questions are not anchored to a common reference point and may thus not be completely comparable across individuals and time. However, we control for a wide range of individual-level confounders, such as age, sex, and education, which have been shown to affect patient satisfaction scores across a given population (Sitzia and Wood 1997, Ware and Snyder 1975). In as reference points for patient satisfaction responses are determined by these factors, potential confounding due to changing reference points have been controlled for in our analysis (Thomas and Penchansky 1984). Third, eight of the 41 provinces that we consider to not have received family medicine-centered PHC system reform at baseline (survey year 2010) already had started to some (minor) extent to introduce family medicine-centered PHC in this year. This partial implementation in a few provinces may have led to an underestimate of the true effect of the introduction of family medicine-centered PHC on patient satisfaction. However, in sensitivity analysis we show that the effect size estimates remains essentially unchanged when we re-assign these eight provinces to the set of control provinces rather than to the set of intervention provinces. Specifically, we reassigned the eight provinces that began introducing family medicine-centered PHC between January 2010 and May 2010 as control provinces and none of the effect size estimates shown in Figure 4.2 changed by more than 5% and none of the determination of significance changed.

Conclusions

Turkey's recent introduction of family medicine-centered PHC led to significant improvements in patient satisfaction across a wide range of satisfaction indicators. This study provides the first causally strong demonstration that a major patient-centered PHC system reform can increase patient satisfaction. Policy makers seeking to improve patient satisfaction through health system reform should consider primary care approaches with elements similar to those used in Turkey's reform initiative.

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Appendix 4.1: Principal Component Analysis

By using principal component analysis, we treat our data as continuous which imposes the assumption that the distances between the ordered categories are equal. As found by Kolenikov and Angeles (2009), this assumption is valid for our data because the response categories are ordered with respect to satisfaction levels and all input variables into the principal component analysis use the same scale (Howe, Hargreaves, and Huttly 2008, Kolenikov and Angeles 2009, Sharker et al. 2014). We find the data across the 23 survey questions are internally consistent, with a Cronbach's alpha of 0.97.

To identify the relevant principal components for additional analysis, we use a cut off of 1.0 to the component eigenvalues (Jeffers 1967). The eigenvalue calculated for a principal component represents the amount of variance in the total data accounted for by a factor. Only the first two components had an eigenvalue greater than 1.0 and combined they explain 65.13% of the total variance in the data (principal component 1 explains 48.75% and principal component 2 explains 16.38%). We use an orthogonal (varimax) rotation for the principal component results so that each variable loads as highly as possible on only one of the two components (see Table 4.2 for principal component factor loadings).

A survey question had to have a factor loading of 15% or greater to be considered relevant to a principal component. Factor loadings are the correlation between the original variables and the component factors estimated in the principal component analysis. A factor loading of 15% signifies that the principal component explains 15% of the variance in the original variable. Survey questions 1 through 17 having factor loadings greater than 15% for component 1, and survey questions 17 through 23 had factor loadings greater than 15% for component 2 (see Table 4.2).

Our use of principal component analysis with ordered-categories imposes linearity assumptions that might introduce bias in our estimates. However, similar to the ordered-logit approach we assume that the distance between each category is equal. Therefore, our principal component results should be viewed as a linear approximation.

Table A4.1: Summary Statistics for Principal Components 1 and 2

	2010		2011		2012	
	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Principal Component 1	-1.00	4.04	0.06	3.06	0.64	2.85
Principal Component 2	-0.52	2.34	-0.09	1.82	0.43	1.66

Appendix 4.2: Sensitivity Analyses

We conduct two additional sensitivity analyses to check the robustness of our results. In the analysis in the main text of the paper, we use these single sample of all respondents who answered all 23 questions. Table A4.2 shows the results of the 23 individual fixed effect estimations (analysis 1) using complete cases by question. For this reason, the number of observations varies by estimation. In Table A4.3 we present the results of the 23 individual estimations where we use multiple imputations to account for missing responses. Therefore, the sample size increases to 101,903 for each of the estimations. These sensitivity analyses confirm the results presented in the paper. In the case of the imputed data, we find that all coefficients are highly significant due to the increased sample size.

Table A4.2: Regression Results: Satisfaction Questions, Complete Case Analysis of Data available for Each Estimation

#	Outcome	Adjusted Odds Ratio*	95% Confidence Interval	p-value**	Observations
1	Making you feel you had time during consultations	1.61	1.18-2.12	0-0003	101,613
2	Interest in your personal situation	1.59	1.15-2.18	0-0005	100,710
3	Making it easy for you to tell him or her about your problems	1.43	1.05 - 1.96	0-024	101,348
4	Involving you in decisions about medical care	1.49	1.07 - 2.0	0-017	100,535
5	Listening to you	1.35	1.04 - 1.72	0-065	101,540
6	Keeping your records and data confidential	1.28	0.93 - 1.77	0-129	96,394
7	Quick relief of your symptoms	1.35	1.01 - 1.81	0-045	100,926
8	Helping you to feel well so that you can perform your normal daily activities	1.42	1.05 - 1.92	0-024	100,287
9	Thoroughness	1.22	0.89-1.66	0-213	101,511
10	Physical examination	1.25	0.91 - 1.70	0-165	101,243
11	Offering you services for preventing diseases	1.25	0.92 - 1.71	0.150	98,120
12	Explaining the purpose of test and treatments	1.46	1.09 - 1.96	0-011	99,647
13	Telling you what you wanted to know about your complaints or disease	1.46	1.07 - 1.97	0-016	101,083
14	Help in dealing with emotional problems related to your health status	1.47	1.09 - 1.98	0-012	97,758
15	Helping you to understand the importance of following his or her advice	1.40	1.03 - 1.91	0-032	100,633
16	Knowing what s/he had done or told you to do during previous contacts	1.63	1.21 - 2.19	0-0001	99,701
17	Preparing you for what to expect from referral to a specialists or hospital care	1.26	0.92 - 1.72	0-145	95,458
18	The helpfulness of the staff (other than the doctor)	1.10	0.82 - 1.47	0-530	100,728
19	Getting an appointment to suit you	1.81	1.25 - 2.62	0-002	87,292
20	Getting through to the Family Health Centre on the phone	1.90	1.28 - 2.82	0-001	81,228
21	Being able to speak to the GP on the telephone	2.31	1.60 – 3.35	<0-0001	79,919
22	Waiting time in the waiting room	1.50	1.09 – 2.07	0-013	100,647
23	Providing quick services for urgent health problems	1.13	0.82 - 1.57	0-448	95,660

*The fixed effect estimations control for time, education, sex, age, and place of residence. Standard errors are clustered at the province level. This model imposes the proportional odds assumption, which means that we assume that the distance between each of the five Likert scale categories is equivalent. The number of observations varies across estimations because we use the sample of conduct a complete case analysis by question.

**By carrying out 23 estimations, we increase the probability of falsely identifying a significant result. To control for this Type I error, we can use the Bonferroni adjustment for our p-values. By doing so, we would only judge results to be significant if the p-value were less than 0-002.

Table A4.3: Regression Results: Satisfaction Questions, Using Imputed Data for Missing Observations

#	Outcome	Adjusted Odds Ratio*	95% Confidence Interval	p-value**
1	Making you feel you had time during consultations	1.61	1.53 – 1.70	<0.0001
2	Interest in your personal situation	1.59	1.51 – 1.67	<0.0001
3	Making it easy for you to tell him or her about your problems	1.44	1.36 – 1.51	<0.0001
4	Involving you in decisions about medical care	1.49	1.41 – 1.56	<0.0001
5	Listening to you	1.35	1.28 – 1.42	<0.0001
6	Keeping your records and data confidential	1.28	1.21 – 1.36	<0.0001
7	Quick relief of your symptoms	1.35	1.29 – 1.42	<0.0001
8	Helping you to feel well so that you can perform your normal daily activities	1.42	1.35 – 1.42	<0.0001
9	Thoroughness	1.22	1.15 – 1.28	<0.0001
10	Physical examination	1.24	1.18 – 1.31	<0.0001
11	Offering you services for preventing diseases	1.26	1.19 – 1.32	<0.0001
12	Explaining the purpose of test and treatments	1.47	1.39 – 1.54	<0.0001
13	Telling you what you wanted to know about your complaints or disease	1.46	1.38 – 1.53	<0.0001
14	Help in dealing with emotional problems related to your health status	1.47	1.40 – 1.55	<0.0001
15	Helping you to understand the importance of following his or her advice	1.40	1.33 – 1.48	<0.0001
16	Knowing what s/he had done or told you to do during previous contacts	1.63	1.55 – 1.72	<0.0001
17	Preparing you for what to expect from referral to a specialists or hospital care	1.26	1.19 – 1.33	<0.0001
18	The helpfulness of the staff (other than the doctor)	1.09	1.04 – 1.16	<0.0001
19	Getting an appointment to suit you	1.81	1.71 – 1.91	<0.0001
20	Getting through to the Family Health Centre on the phone	1.91	1.80 – 2.03	<0.0001
21	Being able to speak to the GP on the telephone	2.33	2.18 – 2.51	<0.0001
22	Waiting time in the waiting room	1.50	1.42 – 1.58	<0.0001
23	Providing quick services for urgent health problems	1.13	1.07 – 1.20	<0.0001

*The fixed effect estimations control for time, education, sex, age, and place of residence. Standard errors are clustered at the province level. We use multiple imputations to calculate the missing observations by survey question using chained multiple imputations with ordered-logit models. There are 101,903 observations for each estimation, which is the total sample size for the TPSHSS 2010, 2011, and 2012 combined. **By carrying out 23 estimations, we increase the probability of falsely identifying a significant result. To control for this Type I error, we can use the Bonferroni adjustment for our p-values. By doing so, we would only judge results to be significant if the p-value were less than 0.002.

CHAPTER 5: CONCLUSIONS

This dissertation demonstrated the importance of political and economic factors in the adoption and implementation of a comprehensive health systems reform. Each chapter analyzed different political economy challenges that the Turkish Ministry of Health had to overcome in meeting its reform objectives. I showed how political economy theories and strategies can be used to structure the analysis of qualitative data on the process of health reform. I used theory to develop hypotheses about the critical factors that explain reform adoption and to motivate my choice of explanatory variables. Through rigorous analysis, I explained how and why specific policies under the Health Transformation Program (HTP) were adopted and implemented, and their impact on a health systems reform outcome. The key findings from the Turkish reform experience can be generalized to identify critical factors potentially needed to adopt and implement future reforms in Turkey, as well as in other countries.

Summary of results

Chapter 2 was motivated by two questions. First, why was Turkey able to adopt a universal and unified health financing system between 2003 and 2008, whereas other countries have failed to do so in recent years? Second, why was the AK Party Government able to adopt a universal and unified health financing system, whereas previous governments in Turkey had failed? I used Immergut's (1992) theory of institutional veto points to structure the initial investigation. I found that Minister of Health Akdağ faced opposition actors within multiple institutions involved in the policy adoption process. While these institutional veto points were critical to structuring the adoption process, they did not determine the policy adoption outcome. Rather Minister Akdağ used carefully constructed strategies based on potential opposition at institutional veto points. I

argued that his strategies to avoid, delay action while facilitating institutional change, persuade and compromise, and overpower at each critical institutional veto point ultimately explained how a universal and unified health financing system was adopted.

Chapter 3 investigated how Minister Akdağ adopted a ban on dual practice for Ministry of Health physicians despite staunch opposition from the Turkish Medical Association. I hypothesized that his actions to “divide and then conquer” physicians in Turkey allowed Minister Akdağ to adopt the dual practice ban, while ensuring services would be available under the newly created national health insurance system. Through qualitative interviews, I identified the critical actions taken to by Minister Akdağ and his team that served to reduce opposition/gain the support of physicians or to delegitimize/penalize groups of physicians between 2003 and 2010. I then analyzed how each of these actions related to specific dividing strategies and contributed to the adoption of the Law on Full-Time Practice in 2010, which officially banned dual practice for Ministry of Health physicians. Specifically, I showed that Minister Akdağ’s actions provided incentives for support, threatened or placed at a disadvantage those in opposition, and created communication channels in ways that either changed the position or the power of physicians relative to the Ministry of Health between 2003 and 2010. I then argued that divisions created as a result of these strategies explain the adoption of the ban on dual practice.

Finally, in Chapter 4 I examined whether the Ministry of Health’s efforts to reform primary health care (PHC) under the HTP using a patient-centered approach to health service delivery resulted in a change in patient satisfaction. Specifically, I used repeated cross-section, quasi-experimental survey data (Turkish Patient Satisfaction with Health Services Survey 2010, 2011, and 2012) to test whether the introduction of the Family Medicine (FM) System between 2010 and 2011 resulted in a change in satisfaction amongst patients. I used two separate outcomes. First, I

used patient ratings along a five-point Likert scale of each of 23 standard questions (based on EUROPEP survey)² of their care seeking experience. Second, I conducted principal component analysis to reduce the 23 questions into two principal components – namely clinical behavior and organization of care - that reveal the underlying construct of patient satisfaction. I then used these two principal components as outcome variables in the analysis. I used a fixed effect approach that took advantage of the staged roll-out of the FM System at the provincial level, to estimate the effect of the FM System on patient satisfaction using the identified outcome variables. I found that the introduction of the FM System significantly improved patient satisfaction in 19 of the 23 survey questions. Similarly, the introduction of the FM System led to a significant increase in patient satisfaction with both clinical behavior and the organization of care. These results show that the Turkish PHC reform between 2010 and 2012 achieved one of its primary goals by causing large increases in patient satisfaction. Importantly, this study provides some of the first national level evidence that PHC reform underpinned by the FM system can effectively improve patient satisfaction.

All three studies have important limitations that are discussed in detail in each of the chapters. Both Chapters 2 and 3 relied on qualitative interview data that may be subject to bias. Additionally, interviews took place in Ankara and Istanbul and therefore reflect the views of stakeholders in these central, urban areas. My use of theory helped to identify key explanatory variables; however, there are also additional factors that contributed to policy adoption. Furthermore, my analysis focuses on specific time periods and there are clearly longer-term

² The European Patients Evaluate General/Family Practice (EUROPEP) Patient Satisfaction Scale, consists of 23 standard and internationally comparable questions asking patients to make assessments of general practice care (see Table 4.1 for individual questions). The EUROPEP scale was developed in 1999 by the European Working Party on Quality in Family Practice (EQuiP), a sub-unit of the European Office of the World Organization of Family Doctors (WONCA) and has been used in 25 European countries to date (Wensing et al. 2000).

implications of each policy that will need to be considered as Turkey enters its next phase of health reform.

Chapter 4 is limited by the nature of the provincial-level roll out of the FM System, as well as the unavailability of time series data beyond 2010, 2011, and 2012. I am unable to analyze any of the mechanisms through which the FM System led to improved patient satisfaction. These mechanisms are critical to understand for policymakers seeking to introduce policies that act on patient demand. Additionally, I can only speculate as to the political importance of improved satisfaction with the FM System for the Ministry of Health and AK Party more broadly. These are all issues that can be explored through additional surveys and qualitative interviews.

Policy implications

The three chapters in this dissertation have implications for policy, both within Turkey and or other countries seeking to introduce health reforms. I discuss some of the specific implications of the individual analyses in Chapters 2, 3, and 4 above. This concluding section synthesizes the lessons that emerge from all three chapters, which are threads that can be traced throughout the entire dissertation.

The key policy message that comes out of this research is that health reform is possible, even in light of opposition and political obstacles. Comprehensive health reform had been on the agenda in Turkey for many years before the AK Party came into office in November 2002. While the AK Party's parliamentary super majority facilitated reform, Minister Akdağ faced institutional challenges, interest group opposition, and a need to gain public support for his policies. Despite these challenges, through strategic action he pushed through large-scale reform over a ten year period that transformed the Turkish health system. This dissertation research is a retrospective analysis that seeks to explain how various policies were achieved, as well as some of their impact.

It is important to note that along with the achievements of the HTP, there were also many tradeoffs, long-term consequences, and abandoned policies that are not the focus of this research.

This dissertation also highlights the importance of strategic action on the part of policymakers. In addition to focusing on the technical elements of the HTP, Minister Akdağ and his team approached health reform within the broader Turkish political and economic context. By doing so, they crafted both the policies, and strategies to achieve those policies, concurrently. My analysis finds that that these strategies are the key explanatory variables that account for policy adoption.

A third implication of this research is that public support is critical to achieving health reform objectives. All three chapters demonstrate the pivotal role public support played in the adoption and implementation of the HTP. As Minister Akdağ recently wrote “This support sometimes becomes a shield, even against some friends, your own political party, and your cabinet” (Akdağ 2015, p. 6). Minister Akdağ was able to strategically use this public support to push through controversial policies, such as a ban on dual practice and a fully unified financing system.

From the outset of the reform, Minister Akdağ was clear on his reform objectives. Whether it was financing, health workforce, or PHC-related reforms, reform objectives were clearly communicated to bureaucrats, politicians, and the public at large. Within this general outcome orientation, he was then flexible as to the specifics of many of the policies. Therefore, he had space to make strategic compromises and negotiations when faced with opposition or pushback.

Finally, while many changes were made to Turkey’s health system over a relatively short period of time, many of the policies were introduced in a gradual way. Each of the three chapters highlights this gradual approach to reform. Instead of beginning with large-scale legislation,

Minister Akdağ began the financing, dual practice, and FM reforms with smaller policies that fed into the larger policy objectives. This approach enabled the Ministry of Health to lay the groundwork for many of the larger policies and also allowed the space to refine policies and programs based on technical specifications and political consequences.

This analysis shows the central role political economy plays in the adoption and implementation of health reform. It begins to clarify some of the questions about *how* a health reform moves from the conceptual phase to concrete policies that can be put forward for adoption and eventually implemented. This research shows how rigorous, theory-drive analyses can provide meaningful contributions both to the literature on health reform, and also to policymakers seeking to introduce change in their own reform contexts. The sustainability of the HTP policies and their long-term effect on the health and well-being of the Turkish people require continued monitoring and evaluation. However, from a short-term perspective, the Turkish health reform experience demonstrates how political rhetoric can be translated into policy action.

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