How 'social' is Turkey?

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Expanding Supplementary Voluntary Private Health Insurance in Turkey: How and Why?

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Abstract

Introduced in 2012, the coverage of supplementary voluntary private health insurance (or supplementary private insurance) in Turkey has rapidly increased over the last years. Since costs for voluntary private health insurance (VPHI), which is offered by private companies without the involvement of the state, have been increasing, supplementary VPHI has become a profitable option to meet additional inpatient and outpatient services in private hospitals uncovered by the public health insurance. Despite the rapid increase in supplementary VPHI coverage, the involvement of the state and business sector in this area has not been studied in detail. However, the expansion of supplementary VPHI cannot be fully studied without delving into this aspect. Therefore, throughout this paper, we will discuss the interplay of the state and business actors in the introduction and rise of supplementary VPHI. In this way, we aim to explain the ways in which supplementary VPHI has become a significant tool in healthcare, which has been shaped by different interest groups and the collective negotiations between the state and business sector. In order to analyze this process thoroughly and delve into state regulation of the broader VPHI market qualitative content analysis of reports prepared by the business sector, official state reports regarding healthcare and (supplementary) VPHI, relevant newspaper articles and legislations will be utilized. In this way, we aim to probe into ways in which the state and the business sector get involved in the supplementary VPHI market and encourage this private insurance scheme further. We argue that state and business may indeed cooperate with each other throughout the policy making processes, and the expansion of supplementary VPHI in Turkey crystallizes this phenomenon.

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List of Abbreviations:

Bağ-Kur: Social Security Organization for Artisans and the Self-employed (*Esnaf ve Sanatkârlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu*

HTP: Health Transformation Program

GSS: General Health Insurance (*Genel Sağlık Sigortası*)

SGK: Social Security Institution (*Sosyal Güvenlik Kurumu*)

SSK: Social Insurance Institution (*Sosyal Sigortalar Kurumu*)

VPHI: Voluntary Private Health Insurance

1. Introduction

In 2003 Turkey initiated its Health Transformation Program (HTP) within the framework of the Urgent Action Program. This transformation was carried out to increase the scope of and access to healthcare services in Turkey. In the following years, the General Health Insurance (*Genel Sağlık Sigortası*, GSS), which became compulsory for all in 2012, facilitated an increase in health coverage to 98 per cent (OECD, 2018). After the introduction of the HTP, one could already see in some Development Plans that voluntary private health insurance (VPHI) would be encouraged to complement public health insurance (T.C. Kalkınma Bakanlığı, 2007, p. 75). In the Development Plan introduced in 2010, public-private partnership is deemed to be necessary for coverage and provision of healthcare services (T.C. Kalkınma Bakanlığı, 2010, p. 98). Even though putting an emphasis on VPHI sounds controversial within the framework of public health insurance, according to the government it is necessary for curtailing the increasing public health spending (T.C. Kalkınma Bakanlığı, 2007, see especially p.70). In Turkey there is still a sharp contrast between the quality of received healthcare services at public and private hospitals. Within this framework, VPHI, which complements public health insurance in the form of providing access to healthcare services in private institutions to an extent that the insurance contract determines, enables subscribers to get a high-class private healthcare service. Needless to say, the given service is considered by the government as sharing the "burden" of provision of all-public healthcare service to the whole population.

In addition to the increasing costs of VPHI, the share of population covered with this insurance scheme in Turkey, which is offered by private companies, has remained at 3% (TOBB, 2017). One recent development that might alter this situation in the medium term is the introduction of supplementary VPHI. According to the Development Plan in 2010 (T.C. Kalkınma Bakanlığı, 2010), along with compulsory public health insurance, particularly supplementary voluntary private health insurance needs to be encouraged in order for individuals to get access to different insurance schemes, and to facilitate public-private partnership. Introduced in 2012, supplementary VPHI has seen a rapid growth in coverage reaching nearly one million people in five years (TOBB, 2017). Like private health insurance, supplementary VPHI covers the costs of services, which are not covered by public health insurance. In the case of Turkey, the difference, however, lies in that supplementary VPHI is much more cost efficient than the former and allows subscribers to access services in those private hospitals, which have a contract with the public Social Security Institution (*Sosyal Güvenlik Kurumu, SGK*). As the costs for VPHI coverage have increased, supplementary VPHI has become a profitable option for VPHI in Turkey to meet uncovered services by the GSS.[1] However, despite being cost-efficient, supplementary VPHI has been a contradictory subject in healthcare research, since it increases income-based inequalities in access to healthcare services at the same time (Yılmaz, 2013). Without a question, this brings decommodification of healthcare services into question.

Even though supplementary VPHI coverage has rapidly increased, the involvement of the state and business sector in the introduction and rise of this healthcare financing tool, and their interaction throughout this process have not been studied in detail. In accordance with that, in this paper, we will discuss the conditions, which have paved the way for the rise of supplementary VPHI in Turkey, and the interplay of the state and business sector in this process.

[1] Cumhuriyet Sigorta, 19.12.2017 *Artan Fiyat Farkettirdi*. Retrieved from: https://www.cumhuriyetarsivi.com/oku/?clipId=32264310&home=%2Fmonitor%2Findex.xhtml

In order to analyze this process thoroughly, we will conduct a qualitative content analysis of reports prepared by the business sector, official state reports regarding healthcare and (supplementary) VPHI, relevant newspaper articles and legislations. Since supplementary VPHI was introduced only with a circular published by the Ministry of Health parliamentary debates did not take place. Therefore, we will use newspaper articles to have access to summaries of the important public and business sector meetings regarding introduction of supplementary VPHI, and interviews conducted with actors from the business sector. In this way, we aim to understand the interplay of the state and business sector in this area, state regulation of the broader VPHI market, and explain on what basis supplementary VPHI is framed as a profitable product.

The paper is structured as follows. In the next section, the literature on (supplementary) VPHI will be reviewed, and a short overview of the Turkish case will be provided. Since in Turkey both the state and business sector play an important role in shaping the VPHI market, the literature on business sector as an interest group in constructing welfare state policies will also be addressed. Without understanding the structure of healthcare system in Turkey, the rise of supplementary VPHI cannot be interpreted thoroughly. Therefore, in the third section, the Health Transformation Program (HTP) and the changing VPHI market over the last decades will be shortly explained. In the fourth section, the regulation of (supplementary) VPHI by the state will be discussed. In the following fifth section, the involvement of the state and business sector in the expansion of supplementary VPHI will be delved into. Before finishing the paper, in the sixth section, the increasing role of supplementary VPHI in collective bargaining agreements will be represented. Finally, in conclusion, the aims and findings of the paper will be summarized, and recommendations for further research will be made.

2. Voluntary Private Health Insurance, the Role of Business, and the Turkish Case

Voluntary private health insurance (VPHI) refers to for-profit health insurance coverage, which is not offered by the state and has become ever more important in many OECD countries (WHO, 2004). According to the OECD taxonomy (2004), VPHI coverage can be investigated under four main categories. These different VPHI schemes are not mutually exclusive and certain schemes may complement each other. Primary private health insurance pertains to private insurance, which is the only available option for individuals either due to not being able to be insured with public insurance (principal cover) or opting out of public coverage as it is the case, for instance, in Germany (substitute cover). The second type, *duplicate private health insuranc*e, offers in addition to public health insurance different services such as in- and outpatient care in private hospitals and faster access to healthcare, even though these services are provided by the public health insurance in public hospitals to a great extent.[2] The third type is *complementary private health insurance* and covers all or part of the residual costs, which are normally not covered or partially covered by public health insurance, which can be seen in form of dental care or medication co-payments. The last type is *supplementary (voluntary) private health insurance* (supplementary VPHI). It refers to a supplementary coverage for the costs, which are not covered by the government at all such as private hospital services for faster access to healthcare services.

[2] Duplicate private health insurance in Turkey is labelled “VPHI” throughout this paper.

According to Sekhri and Savedoff (2005), regulation in VPHI market is essential and would correct market failures. In line with that, Pettigrew and Mathauer (2016) suggest that with proper state regulation, VPHI may "contribute to a country's endeavour to progress equitably" towards universal healthcare. Still, even though some may think that VPHI corrects market failures through increasing access to healthcare services, some scholars claim that VPHI may also cause exclusion of socio-economically deprived (Govender et al.2014; Witter et al. 2017; Paccagnella et al., 2013).

One route for expanding VPHI market size lies in supplementary VPHI. Supplementary VPHI has gained much importance as reflected in the increasing number of studies, since it may provide an easy access to healthcare. Two decades ago, the European Parliament (2000) predicted that the supplementary VPHI market will be playing a significant role in the European healthcare system and covering various health risks because of its complementary status. Since it "provides supplementary cover for faster access and increased consumer choice" (Mossialos and Thomson, 2002, p.24), it has become a significant tool in accessing to and financing healthcare services in most of the OECD countries. However, surprisingly, there is still little evidence that supplementary VPHI is able to reduce public healthcare costs indeed (Stabile and Townsend, 2014).

Although in the literature "business support for preserving and improving welfare policies" has long been ignored, the reality is different (Swenson, 2018), which is also represented by the supplementary VPHI market in Turkey. For instance, in the case of Turkey, the business sector is an important actor that defines the policy agenda by organizing workshops, conferences or writing advice reports for the introduction of supplementary VPHI. However, in the literature, public and private actors have been mostly considered as actors of separate realms, who would not cooperate with each other in agenda setting and policy-making processes. Taking that into account, before thoroughly discussing the cooperation of these two groups in Turkey in this specific field, the increasing role of (supplementary) VPHI both in the world and in Turkey, and the role of business sector in shaping social policies will be discussed in the next sections.

2.1. (Supplementary) Voluntary Private Health Insurance (VPHI) in Turkey

In recent years, research on VPHI in Turkey has increased, even though VPHI market size has remained rather low (Tunç and Kıyak, 2015; Pişkin and Çiftçi, 2007) and coverage increased only moderately over the last years (Yılmaz, 2017). The history of voluntary health insurance as it is today (*özel bireysel sağlık sigortası*) traces back to the 1970s. Private insurance agencies started to provide healthcare insurances in 1976 but VPHI was formally established as a separate branch of insurance by a cabinet decree in 1990[3] after demand for VPHI had increased over the years (Tunç and Kıyak, 2015).

While coverage remains low in comparative terms, one possible route for VPHI expansion could be through state regulation. Dursun and Karaman (2018), for instance, find a positive relationship between tax deductions by the state and VPHI. They also suggest that the state should appropriate funds for individuals who cannot afford VPHI.

In Turkey, according to a report by the Turkey Health Platform (*Türkiye Sağlık Platformu*, TUSAP) (2018) consumers of supplementary VPHI are mostly civil servants couples with stable incomes, and blue-collar

[3] Decree 90/55 was introduced in the official gazette numbered 20430.

workers, who are covered by a group insurance plan by their companies. In recent years, as can be seen in Figure 1, supplementary VPHI coverage has seen a rapid rise and even increased after 2018 despite decreasing VPHI coverage.

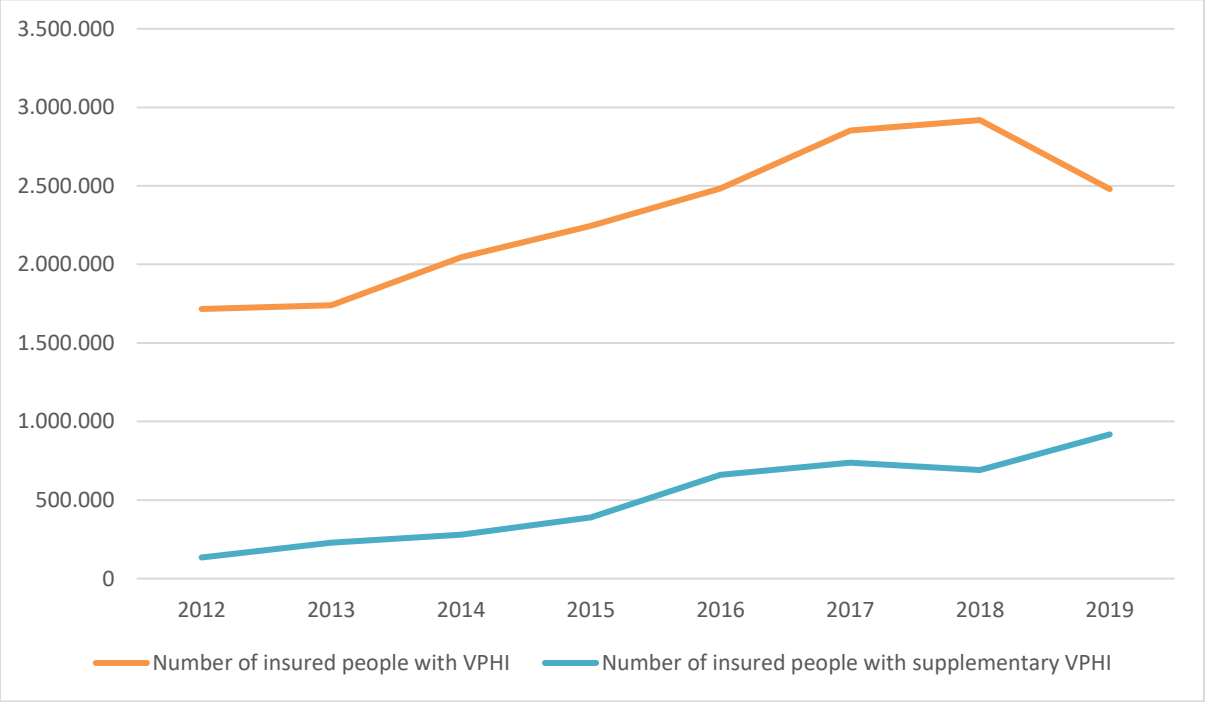

Figure 1. Coverage of Different Voluntary Private Health Insurance Schemes in Turkey

Source: Sigorta Bilgi ve Gözetim Merkezi, SAGMER Istatisikleri. Data retrieved from: https://www.sbm.org.tr//sbm_rapor/sagmer//2016/2016_12.pdf; https://www.sbm.org.tr//sbm_rapor/sagmer//2019/2019_12.pdf

Yet, Önder et al. (2016) depict that approximately half of the population in Turkey still do not have any idea about what supplementary VPHI refers to. There are opposing views on the prospects of supplementary VPHI in Turkey. Some claim that supplementary VPHI can provide an easy and equal access to healthcare (Varoğlu, 2013). However, some disagree with this argument, since supplementary VPHI "strengthens stratification of access to services in the basic benefit package […] as it offers middle- and high-income citizens the ability to differentiate the hospitals they use from low income citizens" (Yılmaz, 2013, p.73). In other words, the access facilitated by supplementary VPHI cannot be considered as an "equal access", since the coverage gaps of the public health insurance are covered through a marketized service. According to this point of view, supplementary VPHI increases already existing inequalities in accessing basic health benefits (ibid). In Turkey, (supplementary) VPHI market is a terrain where the state also plays a significant role in encouraging private insurance coverage. Through the encouragement of supplementary VPHI by the government, the overburdened healthcare system may be relieved to a certain degree and the private providers of (supplementary) VPHI gain from the revival of the voluntary health insurance market. For instance, recently in the Eleventh Development Plan (T.C. Cumhurbaşkanlığı Strateji ve Bütçe Başkanlığı, 2019), it is stated that to develop supplementary VPHI, employers will be encouraged

to insure their employees within the framework of a supplementary VPHI group insurance plan (p.43). In addition, the state and business sector frequently have interacted with each other particularly while introducing supplementary VPHI. Since supplementary VPHI is more cost-efficient than VPHI, the business sector in Turkey has become also an important interest group in this field. Therefore, before delving into the activities of these two sectors, in the next sub-section we will refer to the literature, which address business sector as an interest group in shaping welfare state policies.

2.2. Business Sector's Interests and Involvement in Welfare State Policies

The Turkish case shows that the state and the business sector are both involved in the introduction, fostering and regulation of supplementary VPHI. This is, however, not the first instant where we can see the impact of business sector interests on the creation of policies. Rather, the long introduction process of unemployment insurance in Turkey clearly represent the involvement of the business sector in social policies (Öktem, 2020).

Expansion of the welfare state has been studied widely within the scope of "politics against markets" (Esping-Andersen and Korpi, 1984). Even though the business sector is an important interest group, it has not been prominent in the welfare state literature (Paster, 2013; 2015). Often, it has just been assumed that business simply opposed the welfare state. This is not surprising given the argument that social policies are an outcome of the conflict between employers' and workers' interests (Korpi, 1983). For instance, as represented in the seminal work of Esping-Andersen (1990), decommodification is resisted by employers, since it "strengthens the worker and weakens the absolute authority of the employer" (p.22). However, focusing solely on the conflict between employers and workers while analyzing the establishment of social policies would only show one side of the coin.

Based on the impact of the business sector on active labor market policies in Denmark and Britain, Swank and Martin (2001) depict how "employers are potentially more important than ever in contemporary efforts to restructure the welfare state" (p.892). As shown by Gordon (1994), the New Deal policies in the U.S. introduced by Roosevelt between 1933 and 1939 were shaped by the interest of business groups' interests. Also, focusing on employers' interests and support, Mares (2003) explains how in Germany and France business influenced the historical development of welfare state policies. Moreover, Paster (2011) portrays on what basis employers in the Weimer Republic were motivated to support the introduction of unemployment insurance and how this policy outcome was driven by the "goal of maintaining political influence in a context where policy options are constrained" (p. 6). These works represent clearly that one also needs to delve into the agency of the business sector in social policy development.

From another standpoint, Kaufmann (1991) suggests that public and business sector should not be considered independent from each other, since these two sectors only stand for "distinct perspectives". Therefore, it is important to focus on different patterns of welfare production of each sector. According to Kaufmann, "public sector" neither refers to "state" nor "welfare state". Rather, "public sector" stands for "production and/or allocation which are financed by public bodies" (p. 132). Based on that interlinkage, he develops the concept "social sector" (*Sozialsektor*) which reconciles public, private as well as civil society with each other (Kaufmann, 2000). This sector is underpinned by different small governance models between government and market instead of one form of governance (Kaufmann, 1997; see also Berner et al., 2009) in welfare provision. This "social sector" perspective is important to consider, since it

warns us against internalization of mutually exclusive public and business sector in studying introduction of social policies.

The rise of supplementary VPHI can also not be fully understood without referring to the conditions, which paved the way for this development. As the Health Transformation Program (HTP) may be considered as a milestone of Turkey's healthcare system, in the next session we will therefore summarize shortly the HTP. This will allow us to shed a light on how the business sector in the Turkey played a role in the establishment of supplementary VPHI.

3. Background: The Health Transformation Program and Voluntary Private Health Insurance

Between 2002 and 2013, "a major reorganization of the health care system […through] a new division of labor among the public and business sectors" (Ağartan, 2015, p. 972) took place. That has been brought about by the Health Transformation Program (HTP) which was defined by the Minister of Health as an effort to "equal access to health services for the citizens as individuals with equal rights" (Akdağ, 2008, p. 25). The HTP gathered different social security schemes under the roof of the Social Security Institution (*Sosyal Güvenlik Kurumu*, SGK) with compulsory participation of all citizens in a new General Health Insurance (*Genel Sağlık Sigortasi*, GSS). Before the HTP, the share of the total population covered through any type of health insurance scheme, was only 67 per cent in 2006 (as cited in Bağcı and Atasever, 2020, p.204).

In terms of the administrative structure, before the introduction of the HTP, the social security system was fragmented, with a separate Social Security Organization for Artisans and the Self-employed (*Bağ-Kur*); a Social Insurance Institution (*Sosyal Sigortalar Kurumu*, SSK) for workers; and a Retirement Fund (*Emekli Sandığı*) for civil servants. In addition, means-tested programs provided health service coverage of the poor. Poor elderly and disabled were covered through social pensions introduced in 1976 (*65 Yaş Aylığı*). Furthermore, the Green Card (*Yeşil Kart*) introduced in 1992 provided coverage to the poor. Yet, this program also brought about problems of misuse (Yörük, 2012). The integration of the program to the General Health Insurance was assumed to control this problem through understanding who is really in need.[4] With the reform, Green Card beneficiaries were integrated to the GSS and their contributions to the social security system were covered by the state.

However, the HTP also led to a marketization of the Turkish healthcare system. Based on Bambra´s principle of decommodification, Ağartan (2012) comes up with three different indicators, which underline marketization and decommodification in healthcare systems such as private health expenditure as a percentage of GDP; private hospital beds as a percentage of total bed stock; and number of private and public hospital (p. 459). Accordingly, Figure 2 visualizes the rapid increase in the number of private hospitals in comparison to public and university hospitals.

[4] NTV, 1.7.2011, *2012 itibariyle 'Yeşil Kart'a veda*. Retrieved from: https://www.ntv.com.tr/saglik/2012-itibariyle-yesil-karta-veda,D5VdU_4QNki5wZacV5zIiw

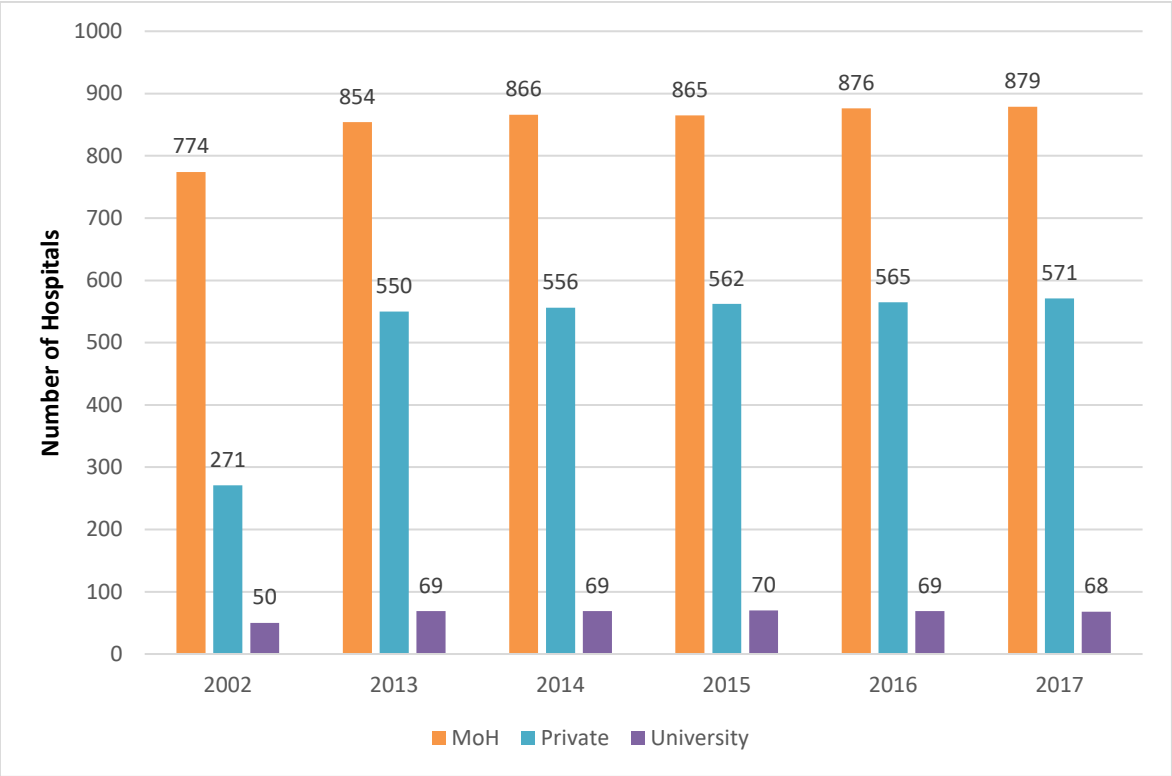

Figure 2. Number of Hospitals by Type

Source: T.C. Sağlık Bakanlığı Sağlık İstatistikleri Yıllığı (2017)

Also, in the Turkish healthcare system when comparing public and private spending on health, one can see that public spending on health by far exceeds private spending (Figure 3).[5] This is surprising given that the government had called for an increasing role of the private providers in Turkey to share the burden of health spending (T.C. Kalkınma Bakanlığı, 2007; 2014).

[5] The total amount of health spending in a country can be examined under two categories as public and private health spending. Whereas public spending is based on state resources, private health spending refers to spending made by households, private health insurance companies, foundation universities, non-profit organizations serving to households (Atasever, 2014).

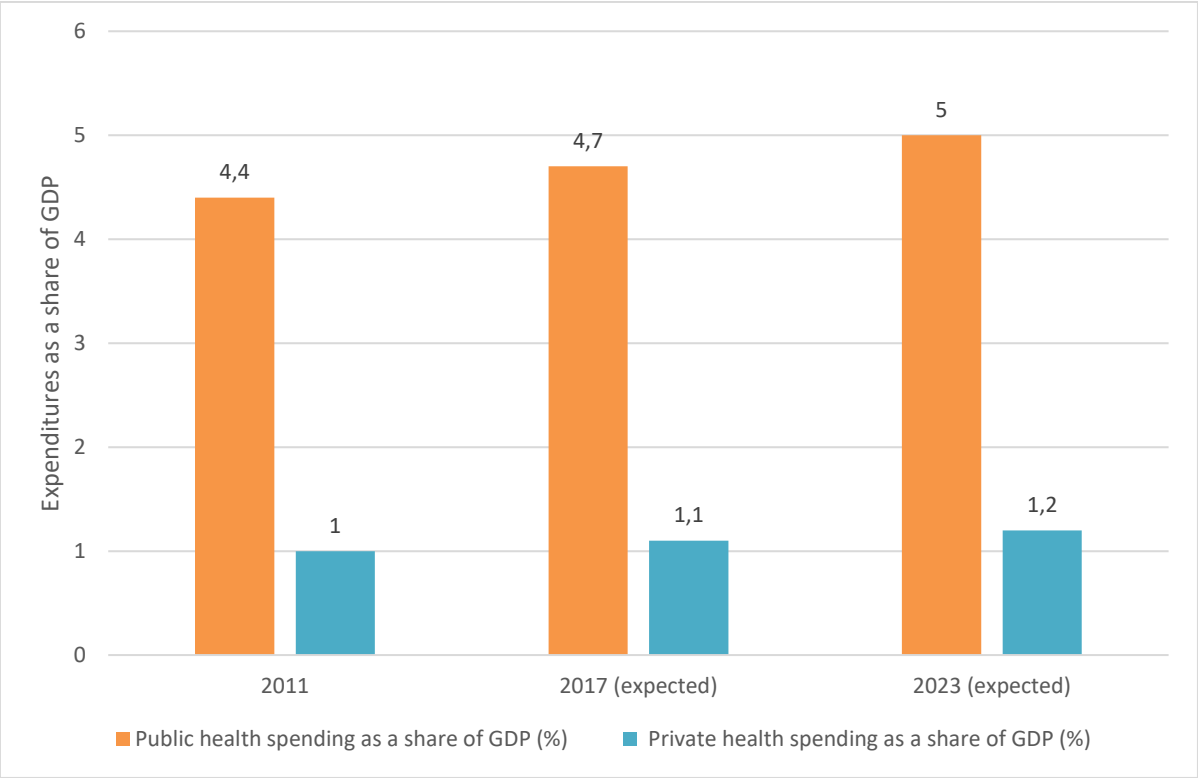

Figure 3. Planned Public and Private Health Spending as a share of GDP

Source: T.C. Sağlık Bakanlığı (2012)

Figure 3 above shows forecasts and plans of the Ministry of Health outlined in 2012 with regards to the development of public and private health spending until 2023. The Ministry aimed for public health spending to reach 5 per cent of GDP in 2023. For private health spending far slower growth was assumed. Thus, the plans by the Ministry were somewhat at odds with the official discourse about the importance of sharing the financing burden between the state and business sector. As Figure 4 below shows, the expenditure forecasts by the Ministry were not reached in 2017, and both public and private spending were markedly lower than the Ministry had planned in 2012. In fact, public spending on health has decreased over the last decade and is far from reaching 5 per cent of GDP as depicted in Figure 4.

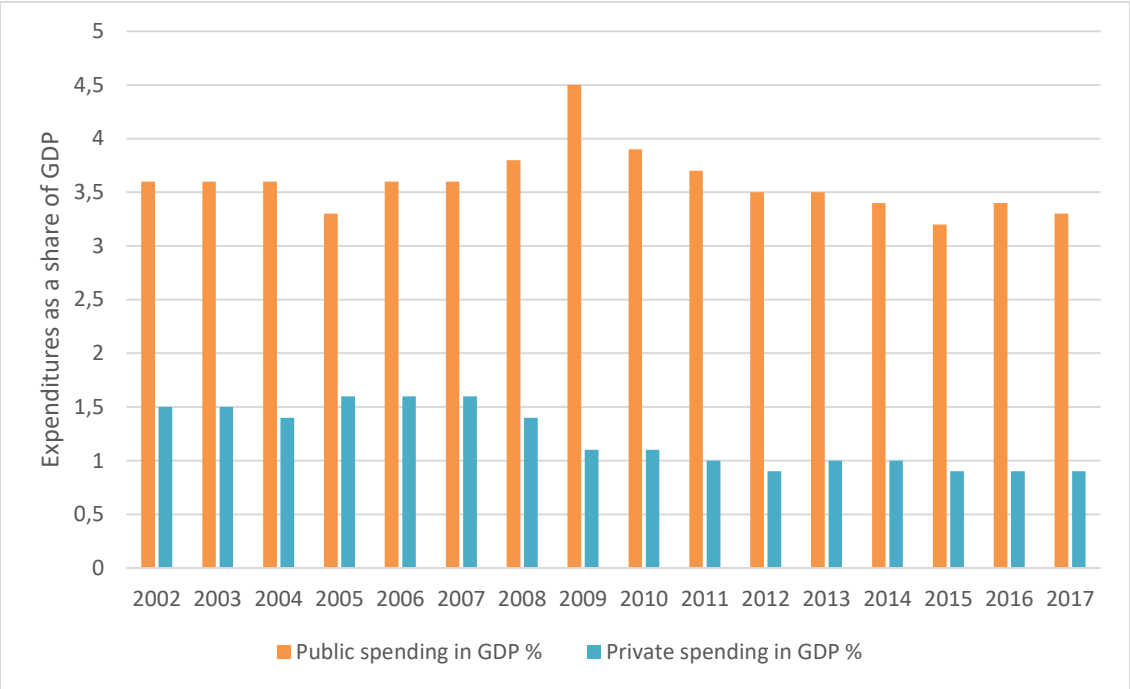

Figure 4. Public and Private Health Expenditure (2002-2017)

Source: T.C. Sağlık Bakanlığı Sağlık İstatistikleri Yıllığı (2017)

Before the reform, the health sector was a combination of four service providers: The Ministry of Health, SSK, university hospitals, and private hospitals (Gürsoy 2015, p.89). The reform integrated private hospitals, which have made a contract with the SGK, to the social security system. Through the reform, people covered with GSS were made eligible to obtain services from private hospitals in return for a co-payment. That is why the Minister of Health argued that the reform prevented "discrimination in health", since there is no longer a distinction between private and public services (Akdağ, 2008, p.69). Also, the Ministry of Health set service quality standards in 2009 for private hospitals.[6] As Figure 5 shows, these reforms appear to have led to an increase in the bed occupancy rates at private hospitals. As Yentürk (2018) suggests, throughout the reform process the increase in public health spending may also be based on this integration of private hospitals to the healthcare system among other elements such as spending on in- or outpatient care, and medical goods.

[6] T.C. Sağlık Bakanlığı (2009), Performans Yönetimi ve Kalite Geliştirme Daire Başkanlığı, Özel Hastaneler Hizmet Kalite Standartları, https://dosyamerkez.saglik.gov.tr/Eklenti/4122,sks-ozel-hastanelerpdf.pdf?0 (last accessed, July 22, 2019).

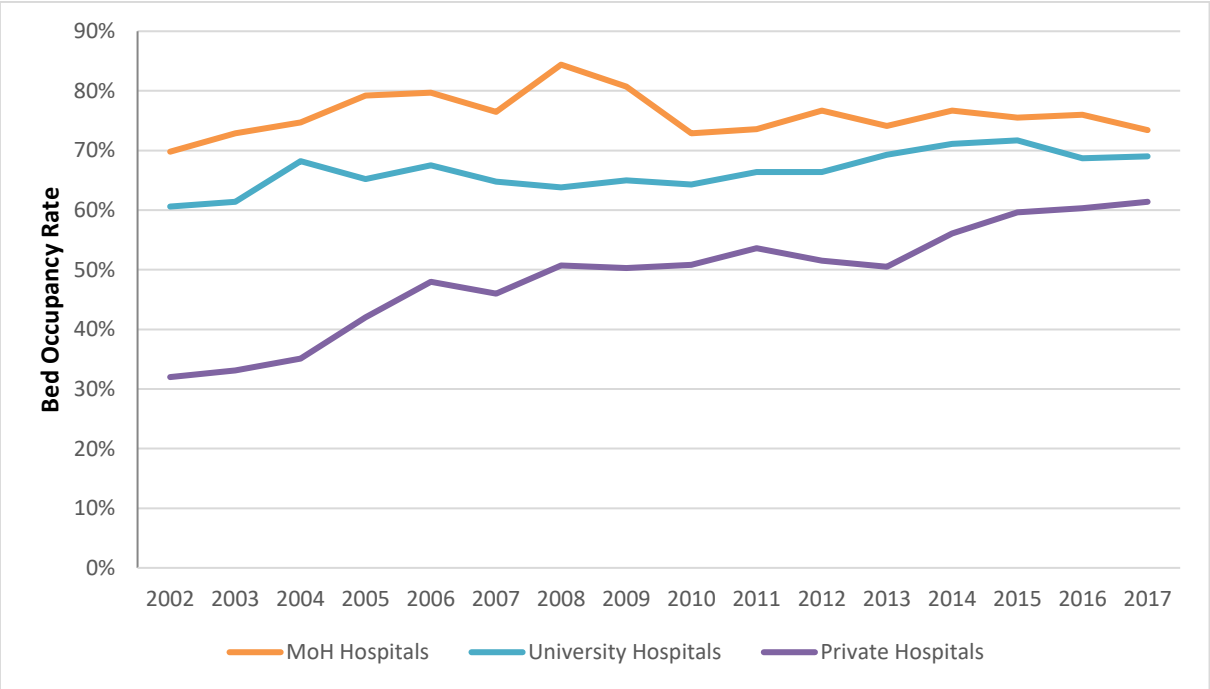

Figure 5. Bed Occupancy Rate in Different Hospital Types

Source: T.C. Sağlık Bakanlığı Sağlık İstatistikleri Yıllığı (2017)

At the same time, with the HTP, the importance of VPHI and supplementary VPHI have also increased. As Ağartan (2012) suggests, HTP not only transformed Turkey's healthcare system, but also the role of the state in healthcare provision. The state is not just the main actor in healthcare financing, but also increased regulation to ensure private healthcare service provisions. In that context where private spending has been expanded through supplementary VPHI and the state withdraws itself from service provision more than before, inequalities in the healthcare system tend to continue (p. 467-468). Therefore, in order to understand increasing marketization in detail, one needs to delve into the ways in which public and (supplementary) VPHI merge with each other through encouragement of the state.

4. State Regulation of Voluntary Private Health Insurance

The guidelines for VPHI were established with a decree in 1993[7] that enabled the undersecretary to set the standards to insurance agencies for VPHI in terms of e.g. setting the amount of the contribution from individuals. This decree was introduced within the framework of the Insurance Regulation Act (*Sigortacılık Murakabe Kanunu*) from 1959. This Act was abolished with the Insurance Act (*Sigortacılık Kanunu*) (§5684/45) in 2007.

As Paccagnella et al. (2013) state, "providing tax incentives for VPHI may be in the public interest because increasing the demand for additional private insurance should mitigate the demand for statutory health services" (p.2). In line with this argument, both VPHI and supplementary VPHI show that the

[7] KHK 510

encouragement of the state through tax incentives play a significant role in the expansion of private insurance schemes. As a part of the comprehensive social security reform in 2006, the state aimed to support the growth of VPHI. Through Article 80(b) in the Social Security and General Health Insurance Law, which was passed in 2006, the state defined that VPHI contribution of an employer up to 30 per cent of the minimum income for his/her employees is not considered as part of earning subject to premium (*prime esas kazanç*). When the amount paid for VPHI is higher than 30 percent of the minimum income, only the rest of the amount, which exceeds 30 percent of the minimum income, is considered as a part earning subject to premium. Following this reform, VPHI coverage did increase substantially to reach more than two million by 2014. Also, the state changed Article 40 and Article 63 of the Income Tax Act §193 with Article 4 and Article 5 in the legislation §6327 in 2012. The change in Article 40 implies that employers may benefit from 15 per cent tax deduction, when they insure their employees with (supplementary) VPHI. The change in Article 63 demonstrates that family members (wife/husband, children) of insured workers may be also subjected to a 15 per cent tax deduction, when their annual insurance expense does not exceed the minimum income. Individuals, who pay contributions for themselves and/or for their families on themselves, are also subjected to this tax incentive, if they provide a receipt of the payment (for a detailed discussion see: Dursun and Karaman, 2018).

The main guidelines regarding supplementary VPHI have been initiated in 2012 as well. However, a by-law regarding these two insurance schemes was introduced only in 2013.[8] This by-law is based on the Insurance Act (§5684) and the Social Security and General Health Insurance Law (§5510) and defines the methods and principles of the VPHI applications (not specific only to supplementary VPHI). It deals with aspects regarding lifelong replacement warranty, annulment, the frameworks of tariffs, obligation of employing a health expert, the supplementary health insurance. With the given regulation, consumers are guaranteed by the state with certain rights in the market through rules and guidelines applicable to the insurance companies. Even though VPHI and supplementary VPHI were not introduced within the framework of HTP per se, this transformation process, which refers to the public-private cooperation in the health system, may have affected the regulation of VPHI market. This new order represents that neoliberalism has not necessarily led to a retreat of the state, rather led to more regulation as a mode of governance tool (Levi-Faur, 2009). Therefore, within that scope, regulation is not solely carried out by the state but addresses "the growth in the number of civil and business actors that ´invest´ in regulation" (Levi-Faur, 2010). Without a question, one can put forward that this new order brings about a new understanding of welfare policies, which reconcile private and public actors in welfare provision.

5. Encouragement of (Supplementary) Voluntary Private Health Insurance through State-Business Relations

In the Turkish case, the involvement of the business sector in this field manifests itself through providing the public sector with advice reports or creating platforms where both sectors are brought together for discussions. Even at the end of the 1990s, one can see that the cooperation between the state and business sector for supporting the VPHI was encouraged by the business sector.[9] Organized by the Association of

[8] Official gazette no. 28800 (The by-law is based on the legislation §5510/98).

[9] Milliyet, 30.8.1998, Güngör, Z., *Sigortasız ekonomi olmaz* (Retrieved from Milliyet Arsiv: http://gazetearsivi.milliyet.com.tr/

the Insurance and Reinsurance Companies of Turkey (*Türkiye Sigorta ve Reasürans Şirketleri Birliği*) and the Association of Medical Institutions (*Sağlık Kuruluşları Derneği*)[10], the workshop "Supplementary Health Insurance Voluntary Working Group" (*Tamamlayıcı Sağlık Sigortası Gönüllü Çalışma Grubu*), which was held in 2003, could be considered as one of the milestones of the interplay of these the state and business sector. This working group consisted of 380 participants including government officials and members of business sector (Çelik et al., 2004). In 2008, a report prepared by the Turkish Industry and Business Association (*Türkiye Sanayi ve İşadamları Derneği*, TUSIAD) referred to supplementary VPHI as a way to overcome the problem of sustainability in healthcare financing, and to provide people with different choices in financing (TUSIAD, 2008, p.2). According to the association, this would share the burden between the public and the private which would bring about a more qualified healthcare service (TUSIAD, 2009). In 2011, in the report prepared by the TUSIAD Healthcare Working Group (2011), it was also recommended that the state should designate the guidelines through a circular and a by-law. Finally, in 2017, TUSIAD established the Supplementary Health Insurance Voluntary Working Group (*Tamamlayıcı Sağlık Sigortası Alt Çalışma Grubu*) to discuss the future of supplementary VPHI (Özsarı, 2017).

Another crucial forum has been the Turkey Health Platform (*Türkiye Sağlık Platformu*, TUSAP), which represents the joint engagement of public, private as well as third sector in healthcare sector. Among the members of this platform, there are senior members of business associations such as TUSIAD, OHSAD, and Independent Industrialists and Business Association (*Müstakil Sanayici ve İşadamları Derneği*, MUSIAD); bureaucrats from the Ministry of Health and the Ministry of Family, Labor and Social Services; and members from the third sector, e.g. from World Health Organization. In a summit conference, which was held in 2018, the Secretary General of the Insurance Association of Turkey, Mehmet Akif Eroğlu, stated that the sector is very content with supplementary VPHI, since only within four years the number of insured has increased from 64.000 to 807.000 (TUSAP, 2018, p. 50). Furthermore, according to Eroğlu, VPHI reached its natural limits because of the individuals´ appropriated budget for private insurance in Turkey is not increasing. That is why the number of insured has not been increasing anymore for years, as Eroğlu puts forward (ibid, p. 49).

As can be understood from the advice reports by the business sector, the joint meetings as well as the conferences, there is a strong interrelation between these two sectors in the healthcare provision governance. In the next sub-section, one case will be represented where supplementary VPHI plays an important role in industrial relations. This case illustrates why supplementary VPHI is considered as a significant tool in addition to its often-stated cost sharing characteristic.

6. Supplementary VPHI: One of the Crucial Clauses in Collective Bargaining Agreements

Over the last years, supplementary VPHI has been used as a collective bargaining provision. For instance, during the collective bargaining between the Turkish Metal Union (*Türk Metal Sendikası*) and Metal Industrialists' Union (*Türkiye Metal Sanayicileri Sendikası*, MESS), workers were granted with supplementary VPHI at the end of the long bargaining process.[11] In another case, after negotiations

[10] The Association of Health Institutions is today's the Association of Private Hospitals & Medical Institutions (*Özel Hastaneler ve Sağlık Kuruluşları Derneği*, OHSAD).

[11] Cumhuriyet, 30.1.2018, *Metalde Zafer Emekçinin* Retrieved from: http://www.cumhuriyet.com.tr/haber/metalde-zafer-emekcinin-916306

between the MESS and the United Metalworkers' Union (*Birleşik Metal İş)*, which is a metalworkers union in Turkey, supplementary VPHI was among the collective bargaining provisions.[12] Recently, in light of the COVID-19 outbreak, the MESS announced that they provided 130 thousand workers from workplaces, which are members of the MESS, with supplementary VPHI.[13] According to the chairman of this industrialists´ union, the inclusion of supplementary VPHI represents "new generation unionism".[14]

As supplementary VPHI has become a recurring demand among workers in collective bargaining, it raises questions regarding coverage of universal basic health coverage and access of workers to healthcare services in Turkey. Considering this demand, providing workers with supplementary VPHI is only a short-cut solution for dealing with the coverage- and access-related problems in the system. The healthcare system in Turkey is underpinned by income-based inequalities and these inequalities are reproduced in collective bargaining as well. Without a doubt, under these conditions, being insured with supplementary VPHI by employers may well be considered as an important acquisition by workers in trade unions. However, as long as there are sharp differences between private and public hospitals in terms of quality and access to healthcare services, supplementary VPHI is destined to stay as a crucial subject in collective bargaining, which shape worker-employer relations. Thus, one could claim that supplementary VPHI plays an important role in industrial relations and this case shows clearly why the business sector is not an unrelated actor in regulating supplementary VPHI. Yet, current problems of the healthcare system could be solved only for a limited period through supplementary VPHI, which has been highly encouraged by the state and business sector over the last decade. For a long-term solution, it needs to be considered how privatization of hospitals, and differences in service quality between public and private hospitals bring about and reproduce inequalities of access to healthcare services.

7. Conclusion

In this paper, we discussed how the introduction and expansion of supplementary VPHI have been shaped both by the state and business sector´s interests in Turkey. Even though public health insurance became compulsory in 2012, as official reports state the healthcare system has been overburdened, and this burden is aimed to be shared between the public and private insurance providers. Since duplicate VPHI packages in Turkey are much more expensive than supplementary VPHI, the latter has become lately a significant actor in healthcare system in Turkey. Even though public spending remains dominant, "a significant transformation in the boundaries among state and market, public and private sectors [has been taking place] in the healthcare system" (Ağartan, 2012, p. 466). Thus, boundaries between service providers and different actors have become quite blurred, so that "the simplistic view that welfare state is an area of class conflict" (Swenson, 2018, p. 23) can no longer fully explain developments in this policy

[12] *Hürriyet*, 30.1.2018, *Metalde Anlaşma Tamam*. Retrieved from: http://www.hurriyet.com.tr/ekonomi/metalde-anlasma-tamam-40726551

[13] *Hürriyet*, 26.4.2020, *130 Bin Çalışana Sağlık Sigortası* Retrieved from: https://www.hurriyet.com.tr/ekonomi/130-bin-calisana-saglik-sigortasi-41503851

[14] *Hürriyet*, 21.4.2020, *Türkiye Metal Sanayicileri Sendikası, 130 bin çalışan için tamamlayıcı sağlık sigortası sağlıyor*. Retrieved from: https://t24.com.tr/haber/turkiye-metal-sanayicileri-sendikasi-130-bin-calisan-icin-tamamlayici-saglik-sigortasi-sagliyor,873983

area. The way this development has been handled in Turkey shows that supplementary VPHI is embedded in the overall framework of the state's healthcare policies.

There is a growing need for further research to better understand the ways in which social policies are developed through a cooperation of the state and business sector. Through probing into the interplay of different actors in the introduction of social policies, it would be possible to have a good grasp of how social policies are shaped by power relations among different actors and how new inequalities are reproduced through social policies. Last but not least, Turkey should be also put in a comparative perspective to understand whether this represents an idiosyncratic case or the cooperation of the state and business sector in this field could be also seen in other countries in similar ways.

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