New public management, physicians and populism: Turkey’s experience with health reforms

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Abstract  Recent debates on the rise of right-wing or neoliberal populism globally have prompted public health and health systems researchers to explore its implications in the healthcare systems. This case study of Turkey’s recent health reform initiative, the Health Transformation Program, aims to contribute to this debate by examining the nexus among populism, professionalism and the contemporary market and managerial reforms, often described as New Public Management (NPM). Building on document analysis and secondary sources, this article introduces a framework to explore whether and how populist agendas grow up in the shadow of NPM policies. We aim to deepen our understanding of the governance settings that might be used in different ways by right-wing populist leaders to advance their agendas. Our research reveals that the NPM reforms in Turkey have opened a ‘backdoor’ through which right-wing populist agendas were supported and the position of the medical profession as an important stakeholder in the institutional settings was weakened. However, what mattered most in the reform process was not the policies themselves but the ways new managerialist policies were implemented. Our analysis makes blind spots of the NPM reforms and healthcare governance research visible and calls for greater attention to implementation processes.

Keywords: health policy reform, new public management, medical profession, populism, Turkey

Introduction

Right-wing populism has received a new relevance in many parts of the world. Public health researchers and health systems scholars have highlighted the threats to health and healthcare systems that are embedded in these developments (Greer 2017, Jarman et al. 2018, McKee 2017, Pavolini et al. 2018, Speed and Mannion 2017). Growing inequality and a backlash against the global goals of sustainable development and universal healthcare coverage are among the major concerns (Gostin and Friedman 2017). However, the effects are far more complex. Scholarly debate has revealed various forms of transformations in the health
professions enhanced through New Public Management (NPM) tools, especially in the medical profession. Research has shown that the outcomes are highly dependent on the institutional contexts (Kirkpatrick et al. 2016, Kuhlmann et al. 2013, McDonald 2015). The professionals respond differently to changing policy and governance arrangements and governments may utilise the professional experts strategically as a governance tool (Burau 2016). However, this scholarship has firstly focused on Western countries (e.g. Kirkpatrick et al. 2016) and secondly, paid very little attention to new populist movements.

This article focuses on the nexus between professions/professionalism and NPM policies in the context of rising concerns over right-wing or neoliberal populism using Turkey as a case study. Turkey provides an interesting case because of its particular combination of NPM reforms since the early 2000s with a populist narrative of political leaders that portrays the physicians as part of the old elite and explains their reaction to the reforms in terms of a refusal to give up their privileges (Agartan 2015, Pavolini et al. 2018). Therefore, this case study makes it possible to analyse both specific forms of new governance mechanisms and different populist discursive tools.

The aim of our analysis is to contribute to critical NPM and governance studies by moving the debates over the responsibility of the health professions (Greer 2017, Leicht 2017, McKee 2017, Speed and Mannion 2017) further and deepen our understanding of the contexts and governance settings that may be used by right-wing populist leaders to advance their agendas. So, the key question is: do populist agendas grow up in the shadow of NPM policies and does this alter the position of the medical profession as an important stakeholder in the institutional settings?

**Methods**

The research design is an exploratory case study of Turkey’s recent healthcare reforms. It is built on qualitative methodology and interpretive analysis. This approach is sensitive to complexity and diversity of governance. It pays attention to the variations of the interrelationships among organisations, professions, practices and experiences on the meso-level of organisations (Kuhlmann et al. 2013, W rede et al. 2006). This context-sensitive case-based approach helps us (i) to explore the bonds between doctors and new governance arrangements in the context of NPM transformations, and (ii) identify whether and how this might be connected to right-wing or neoliberal populism.

For our analysis we develop a matrix which is informed by multi-level governance theory. We understand governance in a broad sense as a framework for negotiating policy interventions (Blank et al. 2018, Greer et al. 2016, Kuhlmann et al. 2016). The benefit of this approach is that it places management changes in context of health systems and policy. Four major dimensions are connected: (i) key characteristics of the healthcare state and institutional contexts of governance (macro-level); (ii) the position of physicians in governance arrangements (macro and meso/organisational level); (iii) the introduction of NPM reforms and particular changes in stakeholders’ involvement (macro and meso/organisational level); (iv) the characteristics of populist discourse.

Data were drawn from primary sources, such as official policy documents, legislative proposals, decrees and bylaws and secondary sources including research evidence published in academic journals and databases; professional reports and evaluation of reforms by the professional associations; and newspaper articles. Data cover the time from January 2003 to October 2017 and were analysed manually by tracking the four dimensions listed above. We paid particular attention to the policy discourse adopted by the reform team and political leaders as
well as the ways NPM policies were implemented in the healthcare system. Documentary anal-
ysis was undertaken with the recognition that they may contain biased or partial information.
Where possible, documentary evidence was cross-checked with primary data sources.

Our analysis focuses on the medical profession for two reasons: firstly, as a professional
group, physicians are most similar and enjoy a high status across countries and secondly, data
are more accessible, comprehensive and standardised compared to other health professions.

**Governance, professionalism and NPM: Developing a framework for analysis**

Professions are occupational groups with specialised knowledge and education. They serve as
experts who produce the evidence to develop policy interventions and they enjoy high levels
of public trust. In this particular role as ‘mediators’ between the state and the citizens, they are
expected to act in the public interest and protect the most vulnerable groups (Kuhlmann 2006,
Le Grand 2010). In the aftermath of the World War II, welfare states in Europe relied on the
professions for allocation of resources and provision of services. From the perspective of citi-
zens, professionals served to translate ‘the concept of social citizenship into the practice of
social services’ (Kuhlmann et al. 2016: 33). It was in this context that the logic of professional
organisation, as Leicht et al. (2009) point out, emerged as the protector of client and public
welfare and professions enjoyed high levels of self-governing powers and trust.

In the healthcare systems of the 20th century European welfare states, the medical profes-
sion has assumed this role and became a key partner to the social contract between the state
and citizens (Moran 1999). In return for their expertise and delivering good quality public ser-
vices, physicians as a group obtained state backing to establish conditions for entry into prac-
tice, control access to technical knowledge and training institutions and protect jurisdictional
boundaries.

By the mid-1970s, the terms of this agreement among the state, citizens and professions –
accompanied by the dominance of medical professionalism – were challenged in the context
of the crisis of Keynesian economics. The subsequent rise of neoliberal political and economic
ideologies in advanced industrial countries initiated a new wave of reforms in the public sec-
tors that are often described as NPM. Some scholars have argued that this shift to NPM
implied real challenges for professions’ expert claims and a decline of medical autonomy and
dominance (e.g. Freidson 2001, Light 1995). Central to the NPM paradigm was the renewed
focus on improving efficiency and accountability through (i) disaggregating large public sector
bureaucracies, reducing organisational hierarchies and expanding new management systems for
monitoring and evaluating professional work, (ii) encouraging competition through a pur-
chaser-provider split and expanding contractual relationships with public and private providers,
and (iii) introducing new payment and incentive mechanisms that reward performance defined
and measured in new ways (Leicht et al. 2009, McDonald 2015).

However, the specific combination of these components and their implementation have
varied from place to place and many have subsequently been transformed. One important
issue is a stronger role of the health professions and more complex forms of governing
through performance alongside the improved participation of patients and representatives of
other health professions. New modes of governing focused on physicians not only as objects
but also as actors directly involved in governance (Kuhlmann et al. 2013, McDonald et al.
2008, Vicarelli and Pavolini 2017). As a result, boundaries between professionalism and
managerialism and between professions and organisations are ‘blurring’ and new forms of
more hybrid, integrated or transformative professionalism are emerging (Denis and van Ges-
tel 2016, Kuhlmann and Burau 2015, Martin et al. 2017, Noordegraaf 2015, Waring and
The various forms of integration of managerial and professional governance tools may create new and hitherto unknown alliances between NPM and other political agendas like populism.

**Populism and new public management: Is there a relationship?**

*Populism and the justice and development party*

There is no single definition that emerges from the burgeoning literature on populism. Despite the recent emphasis on the movements of the radical Right, it has proven difficult to place populism in the Left/Right spectrum and many related but conceptually distinct phenomena (such as authoritarianism, nationalism, xenophobia) were included in this label (Bonikowski 2016, Laclau 2007). Recent social science scholarship introduced an ‘ideational approach’ that does not explain populism as a coherent constellation of certain characteristics, but as ‘as a discourse, an ideology, or a worldview’ (Mudde and Kaltwasser 2017: 5). Laclau similarly conceives populism as ‘a series of discursive resources which can be put to different uses’ (2007: 176) by a plurality of political actors across the ideological spectrum.

At the core of populism is the juxtaposition of ‘common people’ against the ‘corrupt elite’. This conflict serves as the foundation for the anti-institutional or anti-systemic dimension of the populist frames: they generally call for the removal of the political elites who have ‘betrayed’ the people and restore the primacy of the people (Barr 2003, 2009, Mény and Surel 2002). The construction of these categories varies considerably across discourses that are deemed ‘populist’. For example, besides its universal appeal to the people, the populist vision of society espoused by the radical Right often highlights divisions among the citizens and ‘outsiders’ (immigrants, asylum seekers, etc.). Similarly, the ‘elite’ include various kinds of actors ranging from those associated with the state (such as the elected representatives and civil servants) to economic groups (such as the financial elite or industrialists) and to independent groups (such as the journalists and academics).

This kind of a populist discourse poses a serious threat to the social contract that underlies welfare state arrangements in Europe, the US and emerging market economies such as Turkey, India or Brazil. The welfare state embodies the notion of professionals serving the whole population, including the most vulnerable groups, who may be identified in the populist discourse as the ‘outsiders’. But more importantly, there is hierarchy and differentiation built into the system of representation and division of responsibilities within the social contract: Professions act as intermediaries tasked with providing certain services in highly organised governance models and this is how they link the individual to the state. Although most populist actors would recognise their need for the professions to deliver the services they promised to their faithful supporters and the ‘common people’, they often convey a strong distrust of professions as elites. Thus, it is no surprise that in Hungary Viktor Orbán or in Turkey Tayyip Erdoğan sought after a transformation of the civil service law in search for more flexibility to reduce or reshape public bureaucracies. Here, we can identify three factors that may explain this distrust.

- Professions are suspect because they ensure the reproduction of a system (the so-called establishment or *status quo*) which populists would like to dismantle.
- Professions as intermediaries and mediators between the state and its citizens are accused of disrupting the direct and truthful links between the common people and their ‘real’ leaders. The latter would rather bypass the complex institutional mechanisms of network-based governance as their ‘anti-elitist orientation often lends itself to a wholesale rejection of
intermediary institutions’ (Bonikowski and Gidron 2016: 7). Instead, they prefer to work with the individual members of a profession who declare their allegiance to the ‘true’ leaders and stay loyal to the leaders’ agenda.

- Populist discourses denounce professions as part of ‘the elite’, which embodies a clear attack on their morality and legitimacy. Most populist leaders portray the elite as ‘a homogeneous corrupt group that works against the “general will” of the people’ (Mudde and Kaltwasser 2017: 33) and thus use them to unify and mobilise the silent majority. Powerful labels such as ‘corrupt’, ‘self-interested’ or in nationalist terms as ‘working against the interests of the country’ serve to delegitimise the elites and undermine existing institutions. The presumed homogeneity helps populists to include any group on the basis of a broad variety of criteria – the economic elite with links to global networks, professionals, the cultural elite, the political elite, etc. – and serve to deepen economic, racial, ethnic, religious, social and cultural divisions.

Where the politics of NPM meet the right-wing populist agendas

The politics of NPM have created an image of seemingly ‘power neutral’ interventions, that are solely driven by the desire to improve the efficiency and quality of public sector services and that can be assessed through ‘objective’ criteria based on standardised tools and performance indicators (Kuhlmann and Burau 2017). Both policy and science have nurtured this image of ‘objectivity’ through scientific ‘facts’ and evidence and ignored that power and political interests are deeply embedded in NPM. This ‘blindness’ against power and interest may now bounce back and create unintended effects in public sector services, especially healthcare.

At a first glance, the logics of NPM seem to contradict right-wing populist agendas. NPM seeks to strengthen transparency and participation and most importantly to shift power from macro-level regulatory bodies towards more complex and diverse tools operating at the meso-level of the organisation and professional actors with self-governing powers. Yet these two logics have some common grounds: both support strong market power and privatising and oppose welfare policies and an interventionist state.

Although the reasons for opposing state regulation and the policy strategies are different, NPM logics and right-wing populism share common goals: namely, to reduce state power and to undermine the elites who are currently in power. Here, the double-role of professions comes in, who may act as both mediators between governmental politics and citizens and thereby strengthen the state and as powerful elites who may counteract all forms of hierarchical politics (Bertilsson 1990, Kuhlmann 2006).

One important mechanism through which NPM could inadvertently assist populist agendas is through a reconfiguration of the actors and relationships embedded in the social contract. First, NPM has challenged expert knowledge and created new types of professionals positioned between a manager and a professional, especially in healthcare (Kirkpatrick et al. 2016; Noordegraaf 2015; Waring and Currie 2009). These developments may impact in complex ways and might transform the capacity of the health professions to mediate between the interests of the state and the citizens, yet the outcomes are hardly predictable (Figure 2, Arrow 1). Second, NPM has transformed the role of the service user and has created the expert patient and the consumer (Kuhlmann 2006, Tonkens 2016) (Figure 2, Arrow 2). The need for patient participation occupies a central place in the new conceptions of people-centred service delivery.

Considered together these two components illustrate an important characteristic of the new forms of governance, that is, their emphasis on strengthening stakeholder involvement as a major policy lever for encouraging innovation and as a tool for improving performance (Greer et al. 2016). As a result, they might counter the traditional power imbalances between doctors.
and patients (Harrison and Mort 1998) or depending on the particular context, open a window for populist agendas in their quest to speak directly to the people who, as stakeholders, are empowered to make decisions. Furthermore, NPM’s potential to reconfigure the position of the medical profession as a stakeholder may have important implications for its moral status, especially in European welfare states, as the protector of the common good.

In sum, one possible mechanism through which NPM opens up space for populism is challenging the social contract and weakening the position of the professions as mediators between the state and the citizens (Figure 2, Arrow 3). If the service users are created as the real ‘experts’ and the relationship with professionals as that of market subjects, there is little need or space for a mediating role. Moreover, repositioning the physicians as one of the many stakeholders who watch out for their own interests could be one way with which populist leaders could demonstrate the ‘moral failing’ of elites. The charges of moral failing against physicians can have their own negative consequences, like the erosion of public trust and tensions in doctor-patient relationship (Brown and Calnan 2016). These consequences are already evident in the high rates of verbal and physical abuse towards physicians and nurses in many countries including Turkey (Adas 2011, Erdur et al. 2015, Smith 2015, TMA 2014).

So, can right-wing populist leaders act in the shadow of participatory models of NPM and governance to enable their direct connection with the users, despite high levels of professional authority enjoyed by physicians in some contexts? The results call for empirical data and a more differentiated analysis of the relationship among NPM, managerialism, professionalism and populism that make the institutional contexts visible, which may create a ‘window of opportunity’ for populist agendas.

**Case study: Populist discourse in the shadow of NPM reforms**

**Background: Turkey’s healthcare system**

The healthcare system in Turkey has a long tradition of social health insurance (SHI) funded by compulsory contributions from employers and employees. However, unlike other SHI systems in Europe, it was combined with a tax-financed primary care system. A second important difference with the SHI model was the organisation of the delivery system. Until the recent waves of reforms that began in 2003, the majority of the specialists and primary care physicians were salaried state employees. The state owned and operated most of the secondary and tertiary facilities and ran a large web of primary care facilities throughout Turkey. One exception was the Social Insurance Institution (SSK) for private sector employees and blue-collar workers that had its own network of healthcare facilities. The share of private sector was quite limited, comprising of 7.8 per cent of total hospital beds in 2004 but there was a noticeable network of private clinics and offices providing outpatient services (Tatar et al. 2011). Furthermore, the tradition of self-regulation, where corporate actors were responsible for provision and financing of healthcare services, was largely absent. Professional associations and unions participated in central planning initiatives in a consultative capacity but they were not accorded a significant role in regulation. Thus, SHI served mainly as a financing instrument (Wendt et al. 2013).

The state clearly occupied the centre stage in financing, delivery and regulation of healthcare. The Ministry of Health (MoH) assumed day-to-day operating authority with the help of a highly centralised command-and-control system. Provincial health directorates served as the coordinating agencies for the MoH and implement policies in cities and rural areas. At the macro-level, stakeholders, such as the professional associations representing physicians, dentists and nurses or unions representing other health professions and social workers, had a

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'restricted role in policymaking’, participating mostly in a consultative capacity (Tatar et al. 2011: 8; see also Yılmaz 2017). Thus, physicians had a limited role in planning and regulation of healthcare services such as deciding on the suitability and economic efficiency of medical services and diagnostic tools that would be included in the publicly provided benefits package (Wendt et al. 2013). In terms of remuneration, as salaried civil servants, they had no mechanism to negotiate their salaries or the fee schedules. Yet, before the recent reforms, they were allowed to work privately after regular office hours and supplement their incomes.

At the meso-level, physicians occupied important leadership positions such as the chief executive position (Bashekim) in public hospitals and the non-profit university hospitals. As appointed government employees, they were in charge of managing the delivery of medical services. In practice, this governance regime combined some elements of professional authority and values with managerial priorities.

There were many attempts to reform Turkey’s healthcare system but the influence of the NPM paradigm became more noticeable starting in the late-1980s. The 1987 Basic Health Law on Health Services introduced key NPM ideas such as ‘efficiency’ and ‘competition’ for the first time and defined healthcare as a ‘field of economic activity or business’ (Basic Health Law 1987). A quick review of some of the key health policy reports written or commissioned by the MoH and World Bank project documents published during the 1990s demonstrates a new emphasis on organisational problems such as ‘wasteful duplication due to poor planning and overlapping functions among different facilities,’ ‘conflicts between the central and provincial levels of administration and continual referral of even minor matters to higher authorities,’ and ‘low or poor managerial capability of MoH’ (Agartan 2015, MoH 1996; SPO 1990: 4–7; World Bank 1999). To address these issues, reformers proposed NPM-inspired policies such as introducing a purchaser-provider split (competition), expanding the role of private sector, reorganising MoH and creating autonomous health enterprises (disaggregation) and expanding the role of professional managers (Agartan 2015).

Announced in 2003, the Health Transformation Program (HTP) harmonised some components of the earlier reform initiatives into a consistent reform proposal and implemented them systematically (Table 1). In addition to creating a single-payer system by uniting all social insurance funds under the Social Security Institution, the reforms expanded insurance coverage and introduced a purchaser-provider split by transferring all public hospitals to the MoH. In the delivery system, the HTP established a system of family physicians at the level of primary care, granted some degree of autonomy to public hospitals and expanded the role of professional managers in relation to chief physicians. Regulatory reforms also aimed to restructure the MoH to focus on strategic development and planning, improvement of systems of accountability and assessment of performance. In line with the NPM paradigm, other more operational responsibilities, such as those relating to public health, health service delivery or technology assessment, were delegated to new autonomous quasi-public agencies (Atun et al. 2013).

New Public Management ideas were also influential in shaping the HTP’s efforts at redefining the role of patient-consumers. New mechanisms, such as a telephone hotlines and social media accounts run by the Ministry of Health Communications Centre (SABIM), were established to enable ‘service users and citizens to directly express their views on the quality, responsiveness, and availability of health services, including the challenges encountered, their degree of satisfaction, and their expectations’ (Atun et al. 2013: 74). Moreover, new patient rights’ units were established in public hospitals to quickly address the user complaints.

Turkey’s recent experience with populism

There is a burgeoning academic literature and journalistic assessment on Justice and Development Party’s long rein and the growing power of its leader, Mr Recep Tayyip Erdoğan, that
build on various conceptualisations of populism. Some of these analyses focus on unpacking the discursive components of the party’s agenda and Erdoğan’s central role (Akyol 2016, Dincşahin 2012, Erdoğan and Öney 2014, Müller 2016, Selçuk 2016), while others explore the party’s economic and social policies in an attempt to explain its enduring social appeal (Aytac and Önis 2014, Bozkurt 2013, Dorlach 2015, Yıldırım 2010). For instance, Bozkurt (2013) explains the Justice and Development Party’s peculiar combination of economic and social security reforms using Barr’s conception of ‘neopopulism’, which highlights the role of a leader ‘to build personalistic ties to the impoverished masses while pursuing neoliberal economic policies’ (2003: 1161).

Table 1 New public management (NPM) inspired reform proposals before and after 2003

<table>
<thead>
<tr>
<th>Reform proposals before 2003</th>
<th>Health Transformation Program</th>
</tr>
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<tbody>
<tr>
<td>Establish a single-payer system and introduce a purchaser-provider split (1996 Health Reform Proposal – HRP)</td>
<td>Establish a single-payer system and introduce a purchaser-provider split</td>
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<tr>
<td>Encourage private provision of services and competition among health service providers (1987 Basic Health Law – BHL)</td>
<td>Allow private providers contract with the single payer</td>
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<tr>
<td>Reorganise the responsibilities of the MoH and transform it into a planning and managing agency (1987 &amp;1996)</td>
<td>Emphasis on the stewardship role of MoH and organisational restructuring</td>
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<tr>
<td>Encourage public-private partnerships (PPP) to build new health facilities (1987 BHL)</td>
<td>Building a health city/campus for each region</td>
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<tr>
<td>Allow private providers charge higher co-payments</td>
<td>PPP to build new health campuses</td>
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<tr>
<td>Promote private sector investment in health</td>
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<tr>
<td>Create regulatory institutions for drugs or medical devices (1987 BHL)</td>
<td>Create regulatory institutions for drugs or medical devices</td>
</tr>
<tr>
<td>Introduce new payment mechanisms to attract health workers to health facilities in underdeveloped regions (1996 HRP)</td>
<td>National drug policy; new medicine pricing system</td>
</tr>
<tr>
<td>Initiate management training program (1996 HRP)</td>
<td>Introduce performance-based supplementary payments in primary care</td>
</tr>
<tr>
<td>Ensure choice of provider but no clear formulation of patient rights (1987 BHL)</td>
<td>Revisions to performance-based revolving fund payments in public hospitals</td>
</tr>
<tr>
<td>Reform health information systems (1987 &amp; 1996)</td>
<td>DRGs in public hospitals</td>
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<td></td>
<td>Trainings on technical topics and health management for efficient use of resources</td>
</tr>
<tr>
<td></td>
<td>New patient complaint mechanisms, patients’ rights charter</td>
</tr>
<tr>
<td></td>
<td>Establish a national health information system</td>
</tr>
</tbody>
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Source: Authors’ own table.
Alongside the Anatolian middle class that benefited from the economic boom under the party’s rule, the low-income disadvantaged groups constituted Justice and Development Party’s imagined ‘real people’ or ‘silent majority’ as opposed to Kemalist, secular elites and ethnic and religious minorities (Aytac and Onis 2014, Muller 2016). Sowing these divisions within the healthcare system, political leaders often pitted the representative institutions of healthcare professionals and some of the unions, which criticised certain aspects of the reforms, against ‘the people’. While he was serving as the Prime Minister and party leader, Mr Erdogan made it clear that his sympathies lied with those struggling silent majorities rather than public sector workers, who were represented by unions, but nevertheless complained about poor working conditions or eroding job security (Ozden 2014: 167). Also when appropriate, he did not shy away from employing the discourse of victimhood with regards to the ‘real people’ often posing himself as one of the outsiders who suffered under the old Kemalist oligarchy, for instance, when he had to get in line in the dawn to see a doctor in the now-dismantled social security hospitals (Aytac and Onis 2014).

**Populism, NPM and reform: Exploring the nexus**

Many elements in the HTP aimed to improve performance and promote more efficient management of healthcare organisations. Some of these, such as granting autonomy to public hospitals, introducing purchaser-provider split, restructuring MoH as a planning agency or establishment of autonomous agencies, aimed to diffuse the centralised power and created new governance mechanisms. Alongside some degree of institutional autonomy, the new monitoring and data reporting tools, electronic health records, new methods of calculating performance-based payments and even the patient complaint mechanisms had the potential to improve accountability and transparency in the healthcare system. Therefore, it would be incorrect to argue that the form NPM policies took in Turkey opened a window of opportunity for populism. Rather, we need to examine the particular way in which these policies were

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implemented and used by the political leaders to trace the links between populism and NPM policies. Table 2 below summarises our findings using four main categories.

The findings reveal in-depth information on how the implementation processes may be shaped by a populist discourse. First, as discussed in the previous section, the HTP has not prioritised the establishment of mechanisms that would strengthen the participation of stakeholders in decision-making or implementation. Once the initial reform phase that incorporated some degree of consultation with major stakeholders was over and major legislations were passed in the Parliament between 2005 and 2008 (Agartan 2015), the political leaders increasingly questioned the legitimacy of the civil society and representative organisations that were not immediately loyal to the party and tried to undermine their representative role.

In the case of the populist leaders, this takes the form of de-legitimation and often portrayal of the civil society organisations and remnants of the corporatist welfare regime as the opposing side. As Müller (2016) points out, this is a common feature of the populist leaders that provides justification for their claim to direct representation of the ‘real people’. For instance, during a meeting with the representatives of the Turkish Medical Association (TMA) who asked further deliberation on some aspects of the reforms, such as performance payments or measures aimed at lowering infant mortality rates, Minister Akdağ responded, ‘it is not appropriate for the physicians and their professional organization to criticize the general policies of Ministry of Health’ but stated that they would work with the Association on matters relating to health human resources (Medimagazin 2008).

A similar discursive component was visible in Turkey since the early days of reform. The JDP leaders portrayed the TMA and some of the major unions as staunch critics of the HTP (Agartan 2015; NTV 2012, Yılmaz 2017). In their public statements, they described these organisations as self-interested actors who were worried about losing their mandate in the health system rather than working for the public interest. In one specific instance, during the heated discussions on the transfer of the SSI hospitals to the MoH, the Minister of Health responded to criticisms by the unions, asking, ‘why didn’t they come earlier to the defence of the health care professionals who struggled to provide services given inadequate conditions? Why didn’t they organize protests highlighting the limited services provided to citizens in these facilities?’ (Medimagazin 2014: 1).

Second, the reform discourse went beyond a criticism of the position and role of organised interest groups in the healthcare system but had a very particular way of portraying physicians as part of the problem and demonstrating their ‘moral failings’. The reformers emphasised the dual employment and under-the-table payments to physicians as ‘corrupt practices’ and promised to eradicate these practices that ‘exploited’ citizens (Hurriyet 2005, 2010). For instance, describing the full-time work legislation as a ‘historic’ one, the Minister of Health, explained its achievements in terms of burying ‘a system where a citizen could receive care only when she or he paid extra at the university hospitals or went to the private offices of physicians’ (Milliyet 2010).

A recurring theme was ‘physicians as self-interested professionals’ which challenged a key component of medical professionalism, the duty to define and act in the general interest as mediators. The populist discourse posed these self-interested professionals as part of the elite that did not care about the interests of their patients (Adas 2011, Smith 2015). The representatives of the TMA on many occasions publicly criticised this portrayal of physicians and the populist discourse directed at the patients (Smith 2015; TMA 2014). In an interview, the TMA’s President at the time Dr. Bilaloğlu responded: ‘the government found the critical point. Chastise the healthcare workers, blame them and win points from the citizens. Even a Social Security Institute official could state that they would follow the physicians more closely’ (NTV 2012).
Another interesting component of the reform program is the way it redefined the state–patient relations (arrow 2 in Figures 1 and 2). We can identify two aspects in this transformation. First, the establishment of the single-payer system dismantled the previous hierarchical relations among the state and civil servants or full-time workers. Considered together with other key decisions such as removing the gatekeeping function of primary care system, enabling direct and low-cost access to secondary and tertiary care and offering specific services such as cancer treatment or emergency care without co-payments, these reforms demonstrate the reformers’ emphasis on access over costs, quality or efficiency. Taking into account other market elements in the reform program such as encouraging private provision or user-fees, Yılmaz concludes that these reforms reflect the JDP’s ‘synthesis of neoliberalism and populism’ (2017: 155).

The second aspect relates to patients’ rights and how these were explained to the ‘people’. While reducing the distance between the state and citizen/patients and creating more responsive health systems are among the stated goals of the NPM, the way responsiveness is defined may differ depending on the particular context. In the case of the HTP, the party leaders described their administration as ‘different’ from previous ones in terms of ‘encouraging patients to utilize 184 calling centres’ and ‘closely monitoring the complaints filed at these centres’ (Hurriyet 2010). The implementation of these new patient complaint mechanisms illustrates the emphasis on ‘direct’ representation and communication: the telephone hotline or sending complaints directly to the Minister via e-mail were framed as providing ‘direct feedback to the Minister and his team’ and as complementing ‘the formal monitoring systems’ (WHO 2012: 19).

The agencies dealing with these complaints could similarly be described as ‘too responsive’: complaints were steered to the patients’ rights units in the hospitals and call centres (SABIM), which promised to investigate all complaints without serious preliminary review. In 2012, the suicide of one physician in Istanbul after a complaint was filed about her to SABIM created a...
heated debate regarding the process of handling these complaints (Radikal 2012). Yet, it was not followed by new governance mechanisms that encouraged participation of patients and doctors.

In sum, shifts to NPM in Turkey went beyond posing challenges to physicians’ expert claims and ‘the logic of professional organization as an alternative to and protector of client and public welfare’ (Leicht et al. 2009: 584). The reform discourse and particular way in which reform components such as universal access, patients’ rights or full-time law were implemented had a clear populist tone that posed the experts/elites/physicians in opposition to citizens. The party leaders positioned themselves as the defenders of the public interest and the citizens, who have long suffered in the hands of the elite.

Implications of this trend is already visible in rising incidents of verbal and physical abuse directed towards the physicians as well as the nature of complaints filed to SABIM. In terms of other components of the NPM agenda, especially those associated with decentralisation and granting autonomy were reversed in recent months. Loyalty to the governing party (and to the President) has replaced the remaining elements of self-regulation, for instance in the governance of hospitals at the meso-level and partisanship is undermining the public service ethos.

Conclusions

This research has set out to examine the relationships between NPM, professions and populism. We explored whether NPM policies might trigger and mobilise some mindsets that may then open a backdoor or a window through which populist agendas might slip in and grow. Our findings show evidence of populist discourse during the implementation of health reforms in Turkey. In their efforts to justify their claim to direct representation of the ‘real people’, political leaders in Turkey often questioned the legitimacy of professional organisations such as the TMA and some of the major unions, describing them as self-interested actors who were staunch critics of the reforms. By highlighting their moral failings, this discourse fundamentally undermined physicians’ role as mediators who were charged to define and act in the general interest. Moreover, the particular way in which reform components such as patients’ rights or full-time law were implemented had a clear populist tone that posed the experts/elites/physicians in opposition to the citizens.

However, it is important to note that the relationship between populism and NPM is not straightforward and there is no necessary intention of NPM to nurture populism. One major limitation of our study is its exploratory nature and analysis based on one case study. We need more studies that adopt a cross-country comparative approach to deepen our understanding of the relationship between healthcare governance and populist discourse.

The present study has illustrated that a multi-level governance and stakeholder approach and a focus on implementation of NPM-related health policies are key to better understand as to whether and how populist discourses may grow up in the shadow of NPM reforms. This, in turn, calls for greater attention to processes and implementation in healthcare research.

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Declarations of interest

None.

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