SELLING VOLUNTARY HEALTH INSURANCE IN A PUBLICLY-FUNDED SYSTEM: A STUDY WITH INSURANCE AGENTS IN TURKEY

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DECLARATION OF ORIGINALITY

I, Oğuzhan Hışıl, certify that

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ABSTRACT

Selling Voluntary Health Insurance in a Publicly-Funded System:

A Study With Insurance Agents in Turkey

Increasing voluntary private health insurance (PHI) uptake is a global trend. Turkey is not an exception to this trend despite it offers compulsory social health insurance for all. Two types of voluntary PHI are available in Turkey, namely, standard duplicate and supplementary PHI. This thesis explores the dynamics of increase in the PHI uptake through a descriptive analysis of official data and a qualitative study of insurance agent perspectives. Insurance agents are selected as key informants given their strategic position deriving from their closer relations with PHI buyers and holders and their possible role in increasing PHI sales. Seven semi-structured interviews were conducted with insurance agents based in Istanbul. Interview data were analyzed by using thematic analysis method relying on deductive coding approach. The thesis finds that increase in PHI uptake mostly occurs through individual purchases from insurance agents. It also shows insurance agents explain the increase in PHI uptakes in reference to two main factors: PHI buyers' perceived problems in the publicly-provided healthcare services and PHI buyers' and holders' demand for private healthcare services that increased in capacity with the 2003 reform. In addition, this thesis also suggests that the trust relationship established by insurance agents with customers is a crucial factor for the growth of PHI's customer pool. Finally, the thesis provides evidence that the PHI product, which generally appeals to the high-income group in Turkey, has started to attract an economically diverse customer base with the introduction of supplementary PHI after the 2003 reform.

ÖZET

Kamu Tarafından Finanse Edilen Bir Sistemde Özel Sağlık Sigortasının Satımı: Sigorta Acenteleri Üzerine Bir Çalışma

Özel sağlık sigortası (ÖSS) sahipliğinde artış küresel bir eğilime dönüşmüştür. Türkiye herkes için zorunlu sosyal sağlık sigortası sunan bir ülke olmasına rağmen bu eğilimin dışında kalmamıştır. Türkiye'de iki çeşit ÖSS bulunmaktadır: standart mükerrer ve tamamlayıcı. Bu tez resmi verilerin betimsel analizi ve sigorta acentelerinin perspektiflerinin niteliksel olarak araştırılması üzerinden ÖSS satışlarının artmasının arkasındaki dinamiklerini incelemektedir. Sigorta acenteleri ÖSS satın alanlarla kurdukları yakın ilişkilerden ve artan ÖSS satışlarındaki olası rollerinden kaynaklı stratejik pozisyonları sebebiyle seçilmiştir. Araştırma kapsamında İstanbul'daki sigorta acenteleri ile yedi yarı-yapılandırılmış mülakat gerçekleştirilmiştir. Mülakat verileri tematik analiz metodu ile analiz edilmiş ve bu analizde tümdengelimli kodlama anlayışı benimsenmiştir. Tez artan ÖSS satışlarının çoğunlukla acenteler üzerinden gerçekleşen bireysel satışlar doğrultusunda gerçekleştiğini göstermektedir. Sigorta acenteleri bu artışı iki temel faktöre referansla açıklamaktadır: ÖSS satın alıcılarının kamu tarafından sunulan sağlık hizmetlerine yönelik algıladıkları sorunlar ve ÖSS satın alıcılarının 2003 reformu ile birlikte artan kapasiteye sahip özel sağlık hizmetlerine yönelik artan talepleri. Ek olarak, bu tez sigorta acenteleri tarafından kurulan güven ilişkisinin ÖSS müşteri havuzunun genişlemesinde önemli bir faktör olduğunu göstermektedir. Son olarak, bu tez genellikle yüksek gelir gruplarına hitap eden ÖSS ürünün tamamlayıcı ÖSS'nin 2003 yılı reformuyla uygulamaya geçmesiyle birlikte ekonomik olarak daha çeşitli bir müşteri tabanını cezbetmeye başladığını ileri sürmektedir.

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Dedicated to my beloved mother,
Gülay Hışıl

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ABBREVIATONS

AKP	Justice and Democracy Party
BAĞ-KUR	Pension Fund for the Self Employed
ES	Retirement Fund for Civil Servants
GSS	General Health Insurance
HTP	Health Transformation Program
MoH	Ministry of Health
NHS	National Health System
OECD	Organization for Economic Co-operation and Development
PHI	Private Health Insurance
SAGMER	Insurance Information and Management Center
SHI	Social Health Insurance
SGK	Social Security Institution
SSK	Social Insurance Institution
TSB	Insurance Association of Turkey
UK	United Kingdom
UN	United Nations
USA	United States of America
WHO	World Health Organization
WB	World Bank

CHAPTER 1

INTRODUCTION

Healthcare policy is one of the most dynamic policy areas of modern nation states. The most important reason for healthcare policies to be dynamic is that this area is built upon a relationship between state and citizens, and is directly affected by several phenomena such as demographic change, technological development, economic upturns and downturns, or globalization, because these factors have crucial effects on healthcare expenditures and the financing of healthcare.

Healthcare policies affect health outcomes. The importance of the health of the populations is recognized globally and is guaranteed with a variety of social rights in Article 25 of the Universal Declaration of Human Rights as follows: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (UN, 1948, art. 21.3).

Considering the health outcomes, trust is one of the subjects discussed in the literature. The importance of trust in healthcare systems has been discussed from multiple angles. In terms of healthcare, the trustworthiness of healthcare professionals, healthcare institutions (e.g. hospitals, healthcare centers, general practice clinics), and provision of professionalized information forms for patients are all essential for healthcare systems to function for the public good (Rhodes and Strain, 2000). Therefore, trust is linked with better utilization of healthcare (Russel,

2005). More clearly, people's trust in hospitals, insurers, and healthcare systems is important at the institutional level, as it can affect people's use of services (Rowe & Calnan, 2006). The importance of trust is essential especially when patients need to seek healthcare. In the absence of trust, people may delay a consultation with a doctor and lack the necessary treatment (Ahnquist, Wamala, & Lindstrom, 2010).

It has been discussed in the literature that there are various factors affecting trust in the healthcare system. One of these is related to trust in government (Abelson, Miller, & Giacomini, 2009). Popular mistrust in government and politicians was claimed to affect people's trust in healthcare systems. This situation was claimed to be fueled by uncertainty about adequate and fair use of healthcare funds, generally boosted medical sensations and stress on a patient safety culture (Calnan & Rowe, 2006; Entwistle & Quick, 2006). For instance, unproven claims about vaccination practices caused a sensation in media were asserted to affect public trust in healthcare systems around the world (Gille, Smith & Mays, 2016).

Another situation claimed to have an effect on trust in healthcare systems is personal experiences and the transfer of those experiences between individuals (Gille, Smith & Mays, 2016). It has been argued that public trust in the healthcare system is developed in the public sphere where people share their experiences. As can be guessed the initial focus is individual trust (in healthcare systems) as individuals form the public. However, the discourses in the public sphere about people's experiences and the way those people perceive healthcare systems affects wider perceptions of healthcare systems since people share their experiences. Individual trust, on the other hand, is claimed to be shaped particularly when individuals engage with branches of the healthcare system, for instance, an encounter with a general practitioner (Gille, Smith & Mays, 2016).

The erosion of public service ethos caused by entrepreneurial values in the public sphere is another factor considered to erode trust in professionalism that ground the relationship between the public, health professions, and the state, therefore in healthcare systems (Patton, 2002). However, it is also possible to restore the trust damaged by market values. It has been argued that principles of neoliberalism have led to the health policy reforms promoting decreased roles for governments and enhanced cooperation of non-state organizations and private forces and increased choices and responsibility for individuals (Natalier & Willis, 2008). Within the direction of this argument, it has been suggested that people paying for voluntary health insurance, for instance, make rational calculations of losses and benefits of the insurance (Wilson, 1999). The dissatisfaction with services in the public system is claimed to be one of the contributory factors of this calculation.

However, Kristin Natalier and Karen Willis suggest that this argument overlooks the cultural and social contexts. Based on empirical research, they argue that people are not always aware of the choices available to them, or they do not have the expertise knowledge making them able to calculate risks associated with insurance policies. Accordingly, they come to conclusion that the trust relationship is a necessity as a response to uncertainty and complex decision-making process (Natalier & Willis, 2008; Mechanic, 1996). Therefore, they argue that people's expectations from the private health system are not based merely on calculations of cost and benefits of an insurance policy, rather their expectations are grounded more on trust. They suggest that people's trust is established on two bases: the language (but not practices) of health customers and family experiences with private health insurance (Natalier & Willis, 2008). Customers' language of health consumers refers to consumer discourses about healthcare services, such as waiting times, freedom of

choice, and high-quality services. However, although PHI customers have limited information about policies, they make their purchases based on the trust they establish with their service providers. So, the language here is claimed to refer to symbolic action. At this point, Natalier and Willis claim that PHI customers rely on family experiences at the point of policy purchase. Customers are usually loyal to their insurance provider and rarely make explicit choices, even if they are offered other opportunities by different providers (Natalier & Willis, 2008).

While good health outcomes, right to health and healthcare is a shared normative reference point for all countries, healthcare policies, however, vary across countries and this variation has long been a question of great interest in a wide range of academic fields. The variation of healthcare policies between countries might be based on factors such as economic conditions, socio-political factors, population and most importantly, financing and organizational regulation of national healthcare systems. These factors are not static and are usually subjected to the reforms depending on different contexts.

Depending on the healthcare policies of countries, healthcare expenditures constitute a distinct mixture of public and private spending. Especially the health financing, which is considered as an important variable in leading to the differences of policies, has been subjected to the change in the last three decades (André & Hermann, 2009; Yılmaz, 2020).

Among the factors leading to a change in healthcare financing, neoliberalism, a political project that has gained ground since the 1970s, has brought the division of responsibilities between public and private sectors up for social policy discussions (Esping-Andersen, Gallie, Hemerijck & Myles, 2002). Neoliberal policies are those which rely on an understanding that human well-being can be achieved mainly

through strengthened property rights, free market and free trade (Harvey, 2005, p. 2). The idea that the market shows more efficient results in the collection and distribution of resources has promoted market solutions in the field of social policy (Campell & Pedersen, 2001; Harvey, 2005). So much so that international organizations such as the World Bank (WB) recommended policy makers to reduce the role of the state to make larger room for market actors in traditional social policy domains including healthcare (World Bank, 1993). Accordingly, healthcare policies have become one of the social policy fields that have also been influenced by neoliberal ideas including healthcare financing.

While neoliberal approaches to healthcare financing has gained dominance in global policy circles, the factors that cause change in healthcare financing still vary across countries and time. For example, factors such as the aging population, technological development and increasing public expectations about healthcare have been claimed to significantly increase the expenses of countries for healthcare and started to put pressure on the public budget (Blank & Burau, 2007). In connection with this, it is claimed that countries resorted to reform their healthcare system in order to decrease or control public expenditures by balancing public and private health provisions (Béland & Gran, 2008).

Domestic healthcare reforms in the last three decades often include different forms of market solutions. For example, public financing can finance the private healthcare sector, private financing can finance the public healthcare sector, or contracts can be signed between public authorities and private providers (André & Hermann, 2009). Despite their differences, such reforms generally increased the activity of the private health sector within countries (André & Hermann, 2009). The private health sector may include private hospitals, medical products, medicines,

medical staff, a number of management units and employees, and private health insurance (PHI).

The changes in healthcare policies provide, above all, a picture of the increasing role of the private sector in health financing. While at least a policy change that enables individuals to purchase PHI products is necessary, PHI uptake may well increase in healthcare contexts where purchasing PHI is not mandatory. Therefore, understanding and researching the reasons behind increasing PHI uptake in different healthcare contexts will contribute to the enrichment of the discussions of healthcare policy studies. Exploring these changes requires understanding the specific contexts of the countries in which healthcare policies are developed. In this sense, it is very important to understand how specific healthcare systems function on the ground.

Turkey, the select case of this thesis, is one of the countries, especially since the Justice and Democracy Party (AKP) came to power in 2002, leading a comprehensive reform in its healthcare system. In 2003, the Health Transformation Program started to be implemented. Serious changes were made in every aspect of healthcare covering financing and provision. To summarize the crucial changes very briefly, all public hospitals were gathered under the umbrella of Social Security Institution (SGK) and their services were made them available to all healthcare users. With the reform, the entire population were covered under compulsory social health insurance. In addition, a significant increase in the private healthcare provision was observed (Yılmaz, 2017). From this aspect, it can be asserted that with the implementation of Health Transformation Program (HTP), the presence of the private health sector in overall healthcare system has increased. Therefore, the HTP

both increased social security coverage and marketization in healthcare (Ağartan, 2012; Yılmaz, 2013).

The reform created an internal market for healthcare including a sizeable private provision, which is financed by the social health insurance and additional payments by users (Yılmaz, 2020). On the financing side, supplementary PHI was introduced to the market in response to financial risks that may arise from additional payments of users benefiting from private hospitals contracted with the SGK. The number of people with supplementary PHI has increased up to 921.118 in 2019 over the course of the reform. This increase is not exclusive to supplementary PHIs. A considerable increase in the memberships of standard PHI was observed. The coverage rate of 1% in 2000 reached 6.7% in 2017 (% of total population) (OECD, 2019).

This increase in PHI membership, as will be discussed in Chapter 2, is a global phenomenon experienced not only in Turkey but in most of developed and developing countries. In other words, except for few exceptions, there is an increase in PHI membership in almost all Organization for Economic Co-operation and Development (OECD) countries (OECD, n.d.). The existing literature includes various explanations for this increase. The first of these explanations is the dissatisfaction of healthcare users from publicly-provided healthcare services (Aarbu, 2010; Besley, Hall, & Preston, 1999; King & Mossialos, 2000; Taylor-Gooby, 1986). Another reason is that governments support the purchase of PHI policies through various incentives at the level of companies or individuals (Alexandersen & Anell, 2016; Colombo & Tapay, 2004). Finally, the belief that PHIs offer better healthcare to users can be seen as a reason behind this increase (Valtonen, Kempers, & Karttuneen, 2014).

An interesting picture arises when considering the development of the PHI sector in Turkey. On the one hand, with the HTP, social health insurance of the country has become more inclusive and mandatory. In addition, the Ministry of Health's (MoH) data show that users' satisfaction with public health services has increased over the years while vice versa is the case for private hospitals as discussed in Chapter 3. In the sense that people's satisfaction with public healthcare services increased in Turkey, one may expect the country not to follow the same pattern mentioned in the existing literature. Yet, policy implementations discussed in the literature asserted to lead increase in PHI memberships, such as tax incentives, are implemented in Turkey too, as they will be discussed in Chapter 3.

Against this background, this thesis sets out to pursue an alternative explanation for the increase in PHI membership in Turkey. To pursue such explanation, I choose to focus on the perspectives of insurance agents, which may play a role in increasing PHI uptake. PHI sector includes various actors and these actors can vary from country to country. In the case of Turkey case, PHI sector actors include the Insurance Association of Turkey (TSB), insurance companies, and call centers, sales offices, websites, brokers and insurance agents working for these companies. Relying on the findings of my desk research, I found that the large part of the individual PHI and supplementary PHI sales in Turkey (which will be explained in Chapter 4) has been made through the insurance agents. Therefore, I decided to focus on this sales unit in the research. The rationale behind the selection of insurance agents is their strategic position that puts them in close contact with PHI buyers and holders. I believe that their strategic position provides them valuable insights into the changing dynamics of PHI uptake. In fact, as will be presented in

detail in Chapter 4, the trust relations established by the insurance agents with the customers have an important role in expanding their customer base.

In the beginning of this research, I assumed that insurance agents and their successful sales strategies may partly explain the increase in the PHI uptake in Turkey. More specifically, the starting point of this thesis was the following question: How do insurance agents construct the need for PHI schemes in a publicly-funded healthcare system context? What are the major components of private health insurance agent discourses? However, in the pilot interviews, I noticed that the role of insurance agents, their discourses and sales strategies may not be the driver of the increase in PHI uptake in the recent years.

The analysis of findings shows that the reason why insurance agents do not adopt an aggressive sales strategy stems from the fact that their customer profile is already committed to buy PHI at the purchasing stage. They usually extend their customer thanks to their existing customers' references and increasing demand. In other words, the customers reach the agency through their acquaintances who have previously purchased a policy from the same agency. Therefore, it can be argued that the customers come to the agency with a decision to purchase PHI and a certain level of trust at the stage of purchase. Establishing a trust relationship not only with prospective clients but also with existing customers was considered as an important factor. The importance of the relationship of trust in the PHI sector, in particular for insurance agents, and the factors it points to will be discussed in this study.

In the light of this understanding, I have revised my research question accordingly: How do insurance agents explain the increasing PHI uptake in Turkey? What factors do they see important and relevant? How do they explain their role in increasing the PHI uptake? This thesis aims to contribute to social policy and more

specifically healthcare policy studies by providing an alternative perspective on the reasons and dynamics of increase in PHI uptake in an understudied country, where the public funding of healthcare is strengthened in the last decade.

1.1 Data collection procedure and participants

Qualitative methodology was employed within the scope of this thesis. Qualitative researchers examine phenomena within the context of linked social, cultural, political, and physical environments of persons they on (Tolley, Ulin, Mack, Robinson & Succop, 2016). In-depth semi structured interviews were employed in order to explore the perspectives of insurance agents about the rising PHI uptakes.

Insurance agent perspectives lie at the center of this study. Insurance agents are representatives of the insurance companies with which they are affiliated with contract. Within the scope of this contract, they carry out the promotion, marketing activities and sales of the insurance companies' products. While the owners of the insurance agencies are responsible for the first face-to-face meetings with customers, follow-up of sales, payments and damages, and routine meetings with the customer, the agent's employees are more concerned with organizational processes such as preparing policies, providing technical communication with insurance companies in addition to selling of insurance policies.

The research relies on in-depth interviews with 7 insurance agents based in Istanbul. Interviews were performed with 5 males and 2 female participants. Only 2 of the participants had their education in insurance field. The other participants majors were in variety of fields such as management, engineering or social work. The number of years that the participants have been in the insurance sector varies from 8 to 25 years, with an average of 17 years. I wanted to conduct more interviews but the final sample was limited to 7 because of the Covid-19 pandemic. Insurance

agent selection was made among the agents affiliated with the first two insurance companies selling PHI policies the most. Insurance agents often sell many insurance products such as life, private pension, car insurance, standard PHI and supplementary PHIs at the same time. I have learnt from the interviews that PHI policy sales constitute a large part of the revenue of the insurance agents. Among the participants of this study, this rate is at least 60%, it is at most 90% and the average is 65%. All participants were based in Istanbul. Istanbul is chosen deliberately as it is the city where more than half of all individual PHI policy sales were made in the country, while the city is home to less than one-fifth of the country's total population.

Due to the pandemic, interviews were conducted online via Zoom, WhatsApp Video Call, or over phone. The participant information and consent form was sent to each participant via e-mail before these interviews, and then approvals were received via e-mails.

1.2 Data analysis

The thematic analysis was adopted as a data analysis method within the scope of this research. Thematic analysis provides an opportunity to both to reflect reality and to unpick or unravel the surface of 'reality' (Braun & Clarke, 2006). This form of analysis was claimed to be a method for identifying, analyzing and reporting patterns occurring within data. The strategy employed in thematic analysis involved searching for common patterns across the entire dataset rather than within each interview. While determining the patterns, the researcher does not only consider how many times a data unit (i.e. a statement or discourse) repeats in research data but also take the patterns into consideration in relation to the research question (Braun & Clarke, 2006).

The analysis process of data started by transcribing the semi-structured interview recordings into writing form. Then, the transcribed data was carefully read, and patterns related to the research questions were captured with various encodings. These codes were then clustered and grouped in relation to potential answers to the main research question. Mainly, a deductive coding strategy was adopted. Deductive reasoning is asserted to be generated from the research purposes and existing literature, whilst inductive themes stem from the data (Coffey, 2014). So, I predefined set of codes such as "dissatisfaction of healthcare beneficiaries towards public healthcare services" by following and benefitting from the discussions existing in the literature, then, I assigned my qualitative data to these coding set. However, during coding, I thought there were some themes which were difficult to assign to my existing set of codes. Therefore, I also complemented my deductive coding set with a small number of inductively-defined codes such as "trust".

Finally, I came up with 7 number of primary themes, substantiated with several sub-themes. Sub-themes contain different explanations/statements that repeat frequently in interviews and support the main theme. In developing the themes and selecting the illustrative quotations both the occurrence of the statements and the diversity of the responses were taken into consideration.

1.3 Outline of the chapters

Following this introduction, Chapter 2 provides an overview of the literature on the financing of healthcare and introduces different financing types of healthcare system based on OECD's typology. After that, it presents discussions on growing problems in and critics towards different types of healthcare systems. The main axis of these discussions are that the financial pressure that growing problems put on healthcare systems, and the criticisms towards healthcare systems where healthcare is mainly

funded through the market. Continuing from this point, Chapter 2 provides an overview of the literature examining the reasons leading to increase in PHI uptakes as a global trend. Chapter 3 examines the Turkish healthcare policy framework, especially the healthcare financing component. It provides a literature review on the effects of HTP particularly in access to healthcare services. After that, it provides an overview of rising private healthcare sector in Turkey during and after the implementation of HTP. Against this background, the Chapter 4 begins with an overview of the rising PHI sector with a brief historical background and presents the results of the study. Finally, Chapter 5 discusses the implications of this study in relation to its contribution to the existing literature exploring the reasons leading to increased PHI uptake in a country with compulsory social health insurance.

CHAPTER 2

LITERATURE REVIEW

Accessible and affordable healthcare is positioned as an important policy goal in the United Nations (UN) Sustainable Development Goals (SDGs). Among the 17 targets of SDGs, the third target is "good health and well-being". Pursuant thereto, ensuring healthy lives and promoting well-being for all ages is considered as an important step in sustainable development (UN, n.d.).

While ensuring access to affordable healthcare is a global policy objective as part of the SDGs, how this policy objective can be achieved in diverse healthcare contexts is a different question. Ultimately, healthcare policy is considered as a domestic political issue. Healthcare policies are the result of the policy production process of the formal institutions of the countries as well as the interaction of the decisions of the actors formed as a result of the distribution of power influenced by these political institutions (Blank & Burau, 2007).

The diversity of national healthcare systems is grouped into certain categories in comparative healthcare policy studies literature (Freeman, 2000; OECD, 1987; Wall, 1996). In line with these studies, a number of healthcare typologies emerges. The identification of typologies differs in terms of the dimensions that the studies address in healthcare policies (Blank & Burau, 2007; Burau, Blank, & Pavolini, 1985). Three pillars of healthcare systems stand out as crucial dimensions in the healthcare system typologies; namely, *financing* (through taxation, social insurance contributions, private insurance and out-of-pocket (OOP) payments), *provision* (based on state-owned agencies, societal-owned institutions, or private for-profit

facilities) and *regulation* (OECD, 1987; Wendt, Frisina, & Rothgang, 2009). This chapter examines the differences in the healthcare policies of countries in terms of financing, the discussions of typologies are based on these differences, and finally, the position of private health insurance as a thriving financing method.

2.1 Different financing models in healthcare systems

Healthcare financing is a fundamental issue for the sustainability of healthcare systems and, therefore, for the maintenance of human well-being (WHO, n.d.). In fact, for the financial sustainability of the healthcare system, first, a reliable funding source is needed for the payment of the salaries of the health workers, the availability of medical equipment and medicines and the continuation of the medical education. With regard to this, the World Health Organization (WHO) defines health financing as follows:

> "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system… the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal healthcare" (WHO, n.d.)

From this definition, it can be said that healthcare financing is an important issue in terms of shaping people's access to healthcare. In addition to that, how countries structure healthcare financing is an important factor in the differentiation of countries' healthcare systems. Accordingly, healthcare finance has been an important determinant for the typologies of healthcare systems and therefore for comparative healthcare policy studies (Blank & Burau, 2007).

The most prominent typology among healthcare typologies is that of the Organization for Economic Co-operation and Development (OECD) developed in 1987 (OECD, 1987). This typology classifies healthcare systems according to how

healthcare is funded and differences in provision. Based on these two dimensions, OECD proposed threefold typology of healthcare systems that are namely the National Health Service model (NHS), the social insurance model (SHI) and the private insurance model. Similar to the OECD typology, Blank and Burau suggested a categorization based on four different types of funding of healthcare systems. These funding types are (1) direct tax / general revenues, (2) social or state insurance, (3) private insurance, (4) direct payment by users (Blank & Burau, 2007). These models are classified based on certain financial, regulative and provisional similarities and differences. This thesis relies on the OECD typology. According to this typology, the characteristics of healthcare systems are presented as follows.

In the NHS model, health expenditures are financed through the general taxation. In this model, the whole population benefits from healthcare services. On the provision side, public institutions and public healthcare staff healthcare predominantly provide services. The United Kingdom, New Zealand and Sweden are considered as prominent examples of this model (OECD, 1987).

In the SHI model, healthcare is financed through social insurance funds, whereby the employer and employees pay contributions to a certain social insurance fund usually regulated and governed by the state over the certain premium fees that are usually determined within the law. Services are generally provided by public agencies but may also be purchased from private or societal-owned not-for-profit providers by social insurance fund agencies. The most prominent examples of this model are Germany and France (OECD, 1987).

Finally, in the private insurance model, individuals buy health insurance plans either individually or through employment. The insurance policies vary according to differential coverage they offer and mostly according to health risks of

individuals. PHI is defined by the OECD in its publication of Health Statistics 2019: Definitions, Sources and Methods as follows:

> "Private health insurance comprises insurance schemes financed through private health premiums, i.e., payments that a policyholder agrees to make for coverage under a given insurance policy, where an insurance policy generally consists of a contract that is issued by an insurer to a covered person." (OECD, 2019)

There are four main PHI types, namely primary PHI representing the only available channel to accessing health coverage in a country; duplicate PHI offering coverage for healthcare services that is already covered in the public system, whist offering access to different providers, complementary PHI complementing the coverage of government/social insurance by offering compensation for additional costs of services; and supplementary PHI providing coverage for additional healthcare services that are not covered in public forms of financing (OECD, 2016). A prominent example of primary PHI, where PHIs are main source of healthcare finance, is the US (OECD, 1987).

Typologies and categorizations are considered as heuristic tools for describing and analyzing healthcare systems. In this sense, it can be considered as a useful tool for serving a more analytical purpose in the sense that they provide a more deliberate picture of the consequences of healthcare systems for citizens and state budgets (Burau et al., 1985). However, it must also be noted that typologies, in a sense, simplify the important intra-system differences in highly complex healthcare systems by making the unique characteristics of countries' healthcare systems unnoticeable. Besides that, it is claimed that complex and hybrid healthcare systems in East Asian and Southern European countries are not always available for the use of healthcare system typologies (Burau et al., 1985).

2.2 Growing pressure on healthcare financing in NHS and SHI systems

A number of social and economic changes that cause pressures on government budgets in healthcare. Although the problems are considered universal, fundamental differences in healthcare systems also lead to differences in the effects of these problems on these systems. Aging population, rapid advances in medical technology and increasing public demand for healthcare are major problems discussed in literature (Blank & Burau, 2007). These social and economic changes create serious pressures especially on the state budgets or social insurance funds, especially in the NHS and SHI countries, where the financing of healthcare is organized collectively.

Despite differences in healthcare systems, there are common problems that make the sustainability of the healthcare financing difficult, especially in developed countries with NHS and SHI systems (Blank & Burau, 2007). Aging population, rapid advances in medical technology and increasing public demands stand out as prominent problems as these developments put pressure on the financing of the healthcare systems (Blank & Burau, 2007). The main reason behind this increased pressure is that the rate of healthcare expenses rises faster than economic growth rates, which is considered to be unsustainable in long term (Blank & Burau, 2007).

The first development that leads to an increase in healthcare costs is aging population in OECD countries. Factors contributing to aging of populations are asserted to be declining fertility rates and increased life expectancy. The increasing aging populations have a crucial impact on healthcare costs since the elderly population are the heaviest users of healthcare services (Blank & Burau, 2007; Bös & Cnossen, 1992; Lee, 2007.; Rowland, 2012; Uhlenberg, 2009). What makes aging population even more problematic for the financing of healthcare is not only about the reason that elderly people are the heaviest users of healthcare services. In addition to this, as the population get older, the share of working age population and

tax and social insurance base erode (Blank & Burau, 2007; Bös & Cnossen, 1992; Lee, 2007.; Rowland, 2012; Uhlenberg, 2009).

The rapid development of medical technologies is another crucial factor that results in the rising healthcare costs. The volume of technological inputs in the medical interventions have expanded especially in the form of surgical procedures, genetic technology, drugs, imaging technologies or organ replacement techniques. Technology-enhanced medical services tend to cost higher compared to older forms of medical interventions (Aaron, 2003; Blank & Burau, 2007; Bodenheimer, 2005; National Center for Health Statistics, 2009, 2010; OECD, 2006).

Finally, the advancement of medical technology in the medical field and facilitating access to information by the internet and the media, as well as the aging population, have led to a rising public expectation and demand for healthcare. It is claimed that the restriction on these demands has negative consequences for politicians as it will lead to negative reactions by the public and doctors. Accordingly, these expectations led to an increase in the public health expenditures of the countries with NHS and SHI systems (Babalola, 2017; Blank & Burau, 2007).

However, it should be noted that the impact of such global developments on the public expenditures of the countries varies. These factors have a heavier impact on public spending in countries with SHI and NHS healthcare systems where healthcare is financed collectively and access to healthcare is recognized as a social right (Blank & Burau, 2007). On the contrary, in countries where healthcare is predominantly financed through out-of-pocket payments (OOP) and private health insurance (PHI) schemes, these factors have a comparatively less impact on public expenditures (Blank & Burau, 2007). However, there are a number of problems inherent in financing healthcare through OOP and PHI.

2.3 Criticisms towards healthcare financing based on OOP or PHI

There are mainly two ways in which healthcare is financed through market means: OOP and PHI. The main problems associated with private financing of healthcare is the asymmetric information inherent in medical care market (Cardon & Hendel, 2001; Arrow, 1963).

In his outstanding paper entitled Uncertainty and the Welfare Economics of Medical Care, Arrow examines the differences between the actual healthcare market and the ideal competitive market model. He argues that the distinctions between perfectly functioning competitive market and medical care market stem from the inherent characteristics of healthcare market. Arrow explains the fundamental difference in the healthcare market with a condition that he calls uncertainty. He argues that the existence of "uncertainty in the incidence of disease and in the efficacy of treatment" generates an inefficient allocation of resources which can only be compensated with insurance (Arrow, 1963, p. 947).

Uncertainty is considered a problematic factor in many ways in patients' access to medical services in a competitive market. First, the need for medical services, that is to say the demand, is unpredictable. This makes the disease costly as well as risky for healthcare users. Arrow's other critique towards the moral attitude expected of the physicians and healthcare providers. He indicates the risk that profit-oriented market logic may take primacy over patient's objective needs in healthcare. This leads us to another important critique developed by Arrow, that is to say, product uncertainty or asymmetric information in the transaction between providers and consumers of healthcare.

Arrow asserts that there is an information asymmetry between the physician and the patient because of the complexity of medical information. More clearly, the nature of information in medical markets leads patients to an uncertainty about the medical treatment process, its costs (since in the event of an illness or emergency situation, the amount of money the patient has to pay is uncertain) and its effectiveness. This situation, as Arrow argues, creates an imperfect market situation, which accordingly causes market failure, in terms of Pareto efficiency, an economic state where the resources are allocated at their best (Arrow, 1963). Therefore, Arrow concludes, OOP is the worst way of financing healthcare as it leaves patients vulnerable to abuses of healthcare providers.

Arrow argues that an ideal insurance scheme is welfare improving since it is risk pooling. He clearly states that "the nonexistence of suitable insurance policies (…) implies a loss of welfare" (Arrow, 1963, 959). On the other hand, he also claims that the existence of widespread health insurance leads an increasing demand for medical care. Arrow then remarks the control of payments by third parties (i.e. insurers) may effectively limits moral hazard (Arrow, 1963, 961).

It must be noted that asymmetric information is not a concept merely used to express the unequal relationship between the doctor and the patient in terms of having medical information. This concept also refers to the fact that one of the parties has more information about a parameter necessary for the relationship than the other. For instance, Vellakkal examined the reflection of asymmetric information in the PHI sector in the relationship between the agency and the customer (Vellakkal, 2012). He argues that asymmetric information appears in two parameters: asymmetric information on health statuses of prospective clients and health insurance schemes by insurance agent, insurer and client. To sum up briefly, Vellakkal argues

that prospective customers know more about their health status in comparison with insurance agents and insurance companies. When it comes to PHI policy schemes insurance agents are claimed to be more informed about the variety of PHI policy schemes features than customers (Vellakkal, 2012, 7). Accordingly, Vellakkal argues that insurance agents take advantage of the information asymmetry for PHI policies while motivating prospective clients to purchase PHI (Vellakkal, 2012, 13).

PHI is not the only policy recommendation that Arrow's seminal text implies. Arrow argues that these imperfections associated with medical care and structural characteristics of medical market lead to a market failure. He goes on as follows: "[W]hen the market fails to achieve an optimal state, society will, to some extent at least, recognize the gap, and nonmarket social institutions will arise to bridge it" (Arrow, 1963, p. 947). This argument provides a useful ground for the importance of the formation of social institutions financing healthcare services. Today, it is a common, especially for developed countries, to observe the formation of social institutions financing healthcare services either in the form of tax-based financing or SHI.

The main criticism towards PHI healthcare systems about the practices of adverse selection. Contrary to SHI and tax-based/national health systems, PHIs are usually voluntary (OECD, 2016). However, PHI can also be the only available mechanism to protect oneself from the risk of healthcare expenditures as in the case of the US and it may be mandatory particularly for employees earning above a certain income. The prime examples of these countries are Germany and the Netherlands (Goodwin, 2017). In the SHIs and NHSs, financial risks are spread over population and the premiums are determined over individuals' income (through taxation or contributions). However, in PHI schemes, premiums are based mainly on

individual health risks (Stone, 1993). Besides that, PHI companies usually have the authority to reject individuals with high health risk in terms of both medical records and potentially high treatment costs. Therefore, PHI can be discriminatory for those who have vulnerable health conditions such as people with chronic illness or the elderly. This situation leads adverse selection problem. Adverse selection is a condition when the sellers have more information than the buyers have, or vice versa (Neudeck & Podczeck, 1996). Therefore, one of the parties does not have enough information about what their best interest at the time of sale is. According to the adverse selection logic, the people who are more likely to fall ill, therefore, who are most interested in buying PHI policy are considered to be least desirable customers. Thus, they are more likely to be exposed to high costs when they want to purchase PHI. This is another dimension of the difference between publicly funded healthcare systems and privately funded healthcare systems. Accordingly, in healthcare systems where healthcare is dominantly financed through PHIs, the principles of equity and social solidarity are undermined (Kullberg, Blomqvist, & Winblad, 2019).

Adopting a PHI model does not always have the same consequences for citizens. States can intervene in different ways to PHI market, which naturally has quite different consequences, both financially and in terms of provision. In the Netherlands, for instance, PHI companies are required to offer a standard contract in terms of community risk ratings (Kifmann, 2002). Another example exists in Germany where PHI companies are compelled to limit their risk ratings (Wasem, Greß, & Okma, 2004). These regulations have been developed specifically to prevent the exclusion or discrimination of health-vulnerable groups from the system, such as the elderly and people with chronic illnesses.

2.4 Increasing trend in PHI coverage

The PHI has achieved a remarkable market share even in European countries where SHI or tax-funded healthcare financing models are particularly strong. According to OECD data, the total PHI coverage for OECD countries in 2017 is 33.4 percent of the population on average (countries without data are not included in the average). When we exclude the US -where the financing of the healthcare system is predominantly based on PHI- the PHI coverage rate for OECD countries is still 32.3 per cent. Finally, when we include only European countries, the result corresponds to an average of 26.4, which is still a remarkable proportion (OECD, 2019).

There is an increasing trend in PHI coverage rates globally. Since the annual PHI coverage rates do not appear regularly in OECD data, it is very difficult to make comparisons across all countries over the years. However, when the increases in the PHI coverage rates of the countries with SHI and NHS are examined, this increase is evident. For example, in Finland, which has an NHS, the total PHI coverage rate was 10.1% in 2000, and by 2018, it reached 22%. In addition, while the coverage rate was 9.2% in Germany, which is an SHI country, this rate increased to 34.3% in 2017. In Turkey, the coverage rate of 1% in 2000 and reached 6.7% in 2017 (OECD, 2019).

The whole picture of the above is quite interesting and raises new questions for research. On the one hand, statistics show that there is an increasing trend in PHIs, on the other hand countries do not seem to give up their public commitment to financing healthcare. As can be seen in the table below based on OECD data, the ratio of public health expenditures to total health expenditures of countries has risen or remained unchanged significantly since the 1970s (Table 1).

Table 1. The ratio of government health expenditures to total health expenditures

Financing scheme	Government/compulsory schemes					
Provider	All providers					
Measure	Share of current expenditures on health					
Year	1970	1980	1990	2000	2010	2018
Country						
Germany	71.4	77.8	75.4	78.2	83.4	84.5
UK	86.4	89.5	84.3	79.3	83.1	77.1
USA	37.2	42.0	40.0	44.2	48.4	84.5
Sweden	83.8	92.0	79.6	85.5	81.9	83.9
France	74.9	79.6	76.0	78.9	76.3	83.4
Netherlands	..	73.2	71.2	69.0	83.4	82.1
Turkey	..	29.4	59.9	61.7	78.0	78.0

Source: OECD.Stat

International organizations such as the UN, WB, OECD and WHO have organized meetings to highlight the importance of universal health coverage and set their agenda for this purpose (UN General Assembly, 2019). In line with this aim, stakeholders such as development partners, private sector and civil society were also invited to cooperate (UN General Assembly, 2019). Therefore, within the SDG framework, the PHI sector expansion and achieving universal health coverage are not perceived as contradictory (Saltman, 2003; Tuohy, 2012). However, an interesting question arises, how can PHI continue to grow in countries where healthcare systems are based predominantly on SHI and NHS? What could be driving factors behind this increase? Or what are the possible explanations for the apparent increase in consumer demand for private health insurance? Explanations vary.

One of the most common explanations stated in the literature is about the dissatisfaction of people with their publicly funded healthcare systems. The most

pronounced problem of dissatisfaction is about waiting times for operations in public hospitals especially in countries with NHS, particularly in the United Kingdom and some Scandinavian countries (Aarbu, 2010; Besley, Hall, & Preston, 1999; King & Mossialos, 2000; Taylor-Gooby, 1986). The belief that PHI would provide a better quality of healthcare, more option in terms of providers were discussed as other factors behind the increase in the rate of PHI coverages (Valtonen, Kempers, & Karttuneen, 2014).

Other reason mentioned in the literature about the increase in the rate of PHI coverage is the tax incentives introduced to support people to purchase PHI (Alexandersen & Anell, 2016; Colombo & Tapay, 2004). Countries such as Australia, Ireland, the Netherlands, Germany, Switzerland and the United States have introduced regulations such as fiscal subsidies and tax advantages to encourage employers and consumers to purchase PHI. Nevertheless, the actual impact of these incentives on PHI uptake is claimed to be varied across countries (Alexandersen & Anell, 2016; Colombo & Tapay, 2004).

Most of these explanations for increase in PHI uptake are actually related to the perceived problems with public services and policy regulations incentivizing PHI purchases. While these factors may actually be driving the increase in PHI uptake, this increase has to be channeled through a PHI sector. Therefore, PHI sector and actors operating within this sector may well be examined as a mediating factor behind the increase in PHI uptake.

PHI is primarily designed as an insurance product to pose an alternative to OOP that would be made to healthcare providers. Given the uncertainty of the demand for healthcare, the PHI customer is a potential healthcare user rather than an actual one. Hence, customers need to be convinced to purchase PHI policy. In the

decision to purchase PHI policy, there are a number of issues beyond the immediate healthcare needs of individuals. Particularly in countries with SHI and NHS, PHI policy as a product should be positioned against the public funding schemes. Therefore, the seller has to use various discourses that go beyond the potential need for healthcare, which are turned into marketing tools to encourage users to purchase PHI. What discourses motivate individuals in SHI or NHS systems to buy a PHI policy?

The outstanding sociologist Nikolas Rose argues that the rise of a PHI market corresponds to the expansion of the health promotion strategies (Rose, 2009). The promotion of health has become a key characteristic not only of medical market but also of healthcare policies. Health promotion discourse also has been adopted by international organizations like the WHO as a framework for developing policy principles which then has been endorsed by international community (Bunton, Nettleton, & Burrows, 1995). The concept of health promotion is defined by WHO as a "process of enabling people to increase control over and to improve their health" (WHO, 2016). Health promotion may have been incorporated into a discursive tool for the marketing of PHI policies.

The understanding that individuals should have control over their own health brought about the widespread involvement of *individual responsibility* discourse along with *the need* and *freedom of choice* into the health promotion discourses (Anderson & Petersen, 2002; Gabe & Calnan, 2009; Harley et al., 2011; Merrild, Risør, Vedsted, & Andersen, 2016; Rose, 2004, 2009). These discourses cannot be evaluated independently of the ideological climate of the period. Individual responsibility, need and choice are asserted to be key discourses in the developing of neoliberal ideas since 1970s (Gabe, Harley, & Calnan, 2015; Harley et al., 2011).

These discourses have become useful tools when healthcare and consumption intersect.

Anderson and Petersen claim that in a context where health and consumption intersect, the actions of individuals do not take shape only by evaluating their health status. They argue that the adoption of marketing approach in health promotion denotes a difference between the "consumer" and the service providers. This distinction implies that there are needs which can be satisfied through purchase or consumption of goods, which are in this case medical services and products (Anderson & Petersen, 2002). In reference to the PHI product, even if the need does not already exist today, it may arise in the future. Therefore, the concept of risk has a special place in the consumerist discourse around healthcare and PHI. Risk within the context of health promotion becomes an impulsion for individuals to govern themselves and their lives (Rose, 2009). More clearly, when an individual buys a PHI policy, it actually meets a future need against a perceived risk. However, often the policy sellers assess these risks rather than individuals.

Another important discourse that may lead to higher rates of PHI coverage is the discourse of individual choice in healthcare. In several OECD countries, governments use PHIs as policy tools through which they promote the individual choice to fulfil certain healthcare policy goals (OECD, 2016). However, how the concept of choice is adopted is an important matter. Choice discourse has been shaped heavily by the neoliberal ideology (Gabe et al., 2015). Choice is claimed to be adopted in two ways in the neoliberal age: (1) as a means to fulfill the patients' request, to reinforce their autonomy; (2) as a way of strengthening the quality and efficiency of healthcare services through the establishment of competitive environment within provision and finance (Gabe et al., 2015). LeGrand, who

theorized the consumer choice promotion in publicly funded healthcare systems, suggests that increasing patient choice and enhancing competition lead to establishment of incentives for improving performance of healthcare services (Le Grand & Bartlett, 1993). In LeGrand's understanding, people can make rational decisions in healthcare based on the informed knowledge when there are choices available to them. However, this idea neglects the asymmetrical relationship between patients and healthcare providers (Yılmaz, 2020).

The PHI companies emerge as the agents that are expected to act in accordance with the best interests of their principals–the PHI beneficiaries and protect them against the abuses of private providers. Nevertheless, the information asymmetry between individuals and PHI companies are often overlooked. The limited knowledge on the side of patient was recognized by marketing agencies of PHI corporations and this has led to a more collaborative and co-produced (between patient and physician) approach to choice (Gabe et al., 2015). In this co-production of choice in the relationships between PHI companies and individuals, PHI companies may be in a powerful position that can exert influence on such relationships. Therefore, I assume that an additional factor that contribute to the increased PHI membership rates may be the agency of PHI companies either as a driver or as a mediator. The literature on the influence of PHI companies on the construction of new discourses of consumerism in health among individuals is limited. Harley et al., one of the rare examples, examined how PHI companies in the UK and Australia construct health consumers. These researchers analyzed the discourses that PHI companies use through a qualitative research on their websites (Harley et al., 2011).

Several factors explain the PHI market size, the discourses adopted, and even the customer groups PHI corporations target. These factors include the country context where corporations are located, the healthcare systems of those countries, and the regulations around the private health insurance. OECD suggests that private health insurers develop their products to address the gaps in the public system coverages of the countries in which they are located (OECD, 2016). From this point of view, it is possible to argue that private health insurers shape their company policies and adopt discourses according to institutional and legislative context within which they operate.

The study of Harley et al. is a good example in terms of examining the discourses of PHI companies and how their discourses change in the UK and Australian contexts (Harley et al., 2011). The UK and Australia both provide near-universal public health coverage to their population. Therefore, PHIs play a more duplicate or alternative role as is the case with complementary and supplementary PHIs. Despite this similarity, however, the extent of PHI differs in two country contexts due to differences in historical backgrounds and government policies. Historically, the main difference is that Australia has a community-rating system in the determination of PHI policy prices. Insurers are required to provide a uniform premium and cannot assess the applicant's individual or group risk factors when setting premium prices. Such regulations are not available in the UK, so groups such as the elderly and those with a smoking background, for example, face higher premium prices. As a result, more attractive consumers are the younger members for Australian insurers, because insurers who cannot discriminate based on age and illness history tend to target first the younger population which are less costly for PHI companies in general. In the UK, there is no such trend since risks are

individually positioned and prices are determined on this basis. For this reason, the PHI market in the UK is not as strict in terms of their target group as those in Australia. This fundamental difference also affects the marketing discourses of web sites. The findings of Harley et al. indicate that choice and individual responsibility, partnership and healthy-lifestyle are the three important themes appearing on the websites of PHI companies. However, discourse of the PHI companies differs in two countries. For example, hospital and provider preferences are the most noteworthy elements in the discourses of PHI companies in Australia, while "hotel comfort" like style marketing techniques are more emphasized in the UK.

The article by Harley et al. is important in terms of showing the relationship between the PHI companies' marketing discourses and countries' healthcare systems and the agency of PHI companies in adjusting their discourses according to the healthcare system of the country they operate. While health promotion discourse is observed in the PHI discourses in both countries, the study shows that PHI market discourses differ considerably. More specifically, Harley et al.'s study demonstrates that PHI companies actively develop their discourses and marketing strategies in taking into account the country's healthcare system.

2.5 Conclusion

In this literature survey, I have elaborated on the literature handling the characteristics of different forms of healthcare financing, the problems in and criticisms towards different financing models and factors behind the increasing trend in PHI memberships. The financing of healthcare is discussed as an important variable that affects the characteristics of healthcare systems of a country and the problems that arise in these systems. Although an increasing trend in PHI

membership is observed worldwide, the factors that cause this increase are varied. In addition, the marketing discourses of PHI companies is highly influenced by the context of countries' healthcare systems. Therefore, it is essential to examine the factors behind the increasing trend in PHI membership by considering all these dynamics in a context-sensitive manner.

CHAPTER 3

THE TURKISH HEALTHCARE SYSTEM CONTEXT

The previous chapter offered an overview of the emergent issues discussed in the literature related to the financing of healthcare systems. On the one hand, the literature demonstrates similar trends in healthcare financing (such as rising PHI memberships), on the other hand, the healthcare systems and changing socio-economic dynamics in different countries have so idiosyncratic characteristics that it would lead to a superficial conclusion/interpretation if the particular characteristics of healthcare systems are not taken into consideration. In this regard, the specific characteristics of healthcare systems should be incorporated into the analysis of the increasing uptake of PHI observed in the literature. After presenting a brief summary of the historical framework of the Turkish healthcare system, this chapter focuses more on the current situation, position and functioning of PHI market in Turkey.

3.1 A brief overview of the healthcare system in Turkey

Turkey's healthcare system fits the SHI model (Buğra & Keyder, 2006). Historically, Turkey relied upon three-pillar occupational status-based social security system for decades which was merged together with the introduction of the Health Transformation Program (HTP) starting in 2003.

3.1.1 Brief overview of Turkey's healthcare system before the HTP

Three-pillar social security system consisted of the Social Insurance Institution (*Sosyal Sigortalar Kurumu*, SSK) for formal workers founded in 1946, the

Retirement Fund for Civil Servants (*Emekli Sandığı*, ES) founded in 1954, and the Pension Fund for the Self Employed (*Esnaf, Sanatkarlar ve Diğer Bağımsız Çalışanlar Sigortalar Kurumu*, BAĞ-KUR) established in 1971. These social security schemes were actually the combinations of retirement pensions and health insurance funds and the administration of all these institutions were undertaken by state officials. Moreover, the funds of these institutions could be arbitrarily used by the government for purposes other than health and retirement purposes, which showed that the autonomy of social security funds from the government was not strong in the Turkish case (Yılmaz, 2017, 73).

It must be emphasized that these schemes did not cover the increasing number of informal sector workers especially since the 1980s as social security coverage was acquired through formal employment. However, the limited scope of the formal sector became a major obstacle to the universalization of the healthcare system. Therefore, in 1992, the three-pillar social security system was complemented with a new scheme, namely the Green Card. The Green Card was a non-contributory scheme that covers uninsured poor earning less than one-third of the minimum wage. The scheme was financed from the Ministry of Health's (*Sağlık Bakanlığı*, MoH) budget through general revenues.

The financing of these funds was mainly the combination of the contributions of employers and employee, although the ES and Green Card was funded partially by the state through general revenues. All four schemes collected different premium rates and offered different sets of benefits packages for their members. For instance, blue-collar workers had to transfer 5% of their wages to the SSK while employers contributed an additional 6% as a health insurance premium, and BAĞ-KUR enrollees had to pay 20% of their monthly income to the BAĞ-KUR in order to

benefit from the healthcare services (Yılmaz, 2013). In addition to premium rates, all of the scheme's members had to pay copayments depending on the services they receive, as a cost-sharing mechanism (Gürsoy, 2015).

When it comes to the benefits' side, SSK members, for instance, were able to benefit from healthcare services in SSK hospitals and pharmacies. They could only access to the services of public university hospitals through the referral of SSK hospitals. BAĞ-KUR members were able to have medical examinations, test in and outpatient services from a variety of providers. ES members, on the other hand, had the most advantageous benefit packages among the three social security systems as they could directly submit to public university hospitals without referral. Finally, the Green Card holders were allowed to benefit from inpatient services only in public hospitals (Gürsoy, 2015).

Before the HTP was put into practice, out-of-pocket (OOP) payments constituted a significant share in health-care expenditures (20,3% in 2002 and 18,9% in 2003) (OECD, n.d.). This percentage was the total amount of both formal and informal payments. Formal payments corresponded to the purchasing of medications and payments to the SSK hospitals, while informal payments were made to physicians working in public hospitals, some of which were running their private clinics on the side (Tatar, Özgen, Sahin, Belli, & Berman, 2007). Overall, Turkey had a fragmented and inegalitarian healthcare system in terms of provision, administration, financing and access before the HTP was put into practice.

3.1.2 Implementation of HTP and Rising Private Healthcare Sector in Turkey

HTP was introduced by the Justice and Democracy Party (*Adalet ve Kalkınma Partisi*, AKP), the ruling party of the period, in 2003. The party's enthusiasm for

structural reform in many policy areas has been demonstrated as soon as the party came to power. Especially, the government's criticism of inequalities in the healthcare system (especially the civil servants' advantageous position) and the problems in accessing healthcare were the factors that justified the healthcare system reforms.

Right after the AKP came to power the party prepared an emergency action plan outlining the reforms and structural changes that they think the plan would be a solution to the accumulated problems up to that period. In addition, the reason why AKP put emphasize on healthcare reform is that it was an exclusive policy field for the party to reinforce their legitimacy (Ağartan, 2015, 990). According to the emergency action plan, the changes in regard to the healthcare system included several goals pertaining to restructuring of the financing, provision and regulation of the healthcare system. These are:

- MoH is going to be restructured,

- Public hospitals are going to be unified under the purview of the MoH and are going to be authorized self-government in terms of administration and finance,

- Financing and provision functions of the healthcare system will be divided,

- General Health Insurance System will be established,

- A proper referral system is going to be established through family medicine practice,

- Special attention will be given to maternal and child health,

- Preventive medicine will be popularized,

- The private sector investment in health will be supported (State Planning Organization, 2003).

In December 2003, MoH published a report detailing the framework of the healthcare reform. Addressing the functioning of the healthcare system of the country from past to present, the report then presented the general framework and components of HTP. Accordingly, they presented that HTP had 8 components, most of which was in line with the goals of emergency plan: (1) Making the MoH as the planner and controller, (2) gathering all citizens under General Health Insurance (*Genel Sağlık Sigortası*, GSS), (3) making healthcare services accessible and responsive (by strengthening primary healthcare and referral chain; and by giving health enterprises financial and administrative autonomy), (4) providing health manpower equipped with knowledge and motivation, (5) supporting the system by enhancing education and science, (6) introducing quality measures for the healthcare system, (7) promoting institutional establishment that will be able to catch up international norms on the issues of standardization, authorization, and rational use of medicine, equipment and medical services, (8) to establish a health information system in order to make effective information at decision-making process accessible. Each of these aims heralded extensive transformations in healthcare management, provision and financing (Ministry of Health, 2003).

With the introduction of HTP, there have been significant changes in the financing of the healthcare system. Social Security Institution (*Sosyal Güvenlik Kurumu*, SGK) was introduced as an umbrella institution equalizing benefit packages of the former fragmented social security system. SGK was also authorized to determine basic benefits (the amounts and durations of diagnostic services, and the medications and treatments covered by GSS).

With the introduction of GSS, health insurance funds were separated from pension funds. Eventually, people lacking formal employment or coverage through

familial ties were mandated to contribute to the social health insurance fund (Gürsoy, 2015; Yılmaz, 2013; Yılmaz, 2017). For those who are unable to afford (those whose monthly income is less than one-third of the minimum wage) the premium contributions are covered by the state from the general budget. GSS has also become a better solution to the low coverage rates of the former social security system since it extended coverage to the entire society at least on paper. While the social insurance type financing characteristics of the system remained intact, HTP introduced new financing mechanisms.

First of these additional sources is the introduction of state contribution, an amount of 25% of all premiums collected monthly, to the social health insurance fund. Second, patient contributory payments (for all hospital visits, and medications; the level of payment changes depending on the hospital type and the number of prescriptions, for example, the primary healthcare services visit and some defined health conditions such as cancer were not subjected to payment) were introduced. The contributory payments were actually presented as part of the government's intention to promote the rational use of healthcare, as indicated in the HTP report (Ministry of Health, 2003). It was claimed that socio-economic problems such as high level of informal economy, rising unemployment rates are main obstacles for the country's healthcare system to achieve universal healthcare coverage aims, and yield insufficient and unsustainable premium resources (Ökem & Çakar, 2015; Yaşar & Uğurluoğlu, 2011). In addition to that, contributory payments did not affect all income groups economically at the same level. Contribution payments are a flat-rate fee, independent of the income levels of individuals. This situation has the potential to be an obstacle to low-income groups' access to health and medication (Yılmaz, 2013), and it was claimed that the contributory payments are detrimental

implementation that harms social state characteristics of the country (Yıldırım, Yıldırım & Erdem, 2011).

The other dimension brought by the HTP is the incorporation of the private healthcare providers to the social health insurance through additional payments (co-insurance) and supplementary private health insurance schemes. With the new system, the state provided citizens access to private hospitals (those contracted with SGK) through additional payments. The maximum amount of these additional payments is determined by the SGK. In addition, private hospitals are categorized according to the quality level criteria and the level of additional payments varies in accordance with this categorization. The maximum amount of additional payments has been increased over the years (from 30% to 200% of the costs of treatments). Therefore, it can be argued that rising amount of additional payments may make it harder and harder for lower- and middle-income groups to benefit from the collaboration between SGK and private hospitals. It is claimed that this cooperation developed by the state between SGK and the private health sector has a negative aspect that leads to the establishment of a stratified healthcare system in which the income status of citizens is increasingly important in determining their access to healthcare services of different quality (Yılmaz, 2013). In other words, it can be claimed that there is a situation in the new healthcare system that middle-upper and high-income groups can access state-subsidized private healthcare services more easily. This creates an unequal situation for citizens in terms of their access to healthcare.

Additional payments also paved the way for the emergence of the supplementary PHI sector. Supplementary PHIs provide protection for additional payments that citizens must pay when they receive treatment in a private hospital

working as part of a SGK contract. SGK also offers citizens the benefit of a tax reduction in order to increase the demand for supplementary PHIs. Accordingly, a 15% tax reduction is provided on the total premium that is paid to the supplementary PHI (Ministry of Finance, 2012). The only condition to benefit from this tax reduction is to receive more salary than the minimum wage. There is no standard policy price in determining PHI premiums, criteria such as age, gender and health history of the individual who wishes to buy are taken into consideration when determining the price of the policy by the insurance company. These collaborations established between the public and private health sector have increased the attractiveness of the private healthcare sector for users.

With the reform, both the capacity and the use of private healthcare services has increased. The MoH data shows the increase in the interest in using private healthcare services. First, a 1.5-fold increase is observed in the number of beds in private hospitals from 2002 to 2018. In addition, a 13-fold increase in the number of applications to private hospitals is observed from 2002 to 2018. While the use of healthcare services increased in general, this increase is 4 times in MoH hospitals (Ministry of Health, 2018). A similar increase can be seen in the number of surgeries and the number of inpatients. The total number of surgeries in private hospitals has increased approximately 7 times from 2002 to 2018. This increase is approximately 2.5 times in the state hospitals affiliated to the MoH. While there is an increase of 7.2 times in the number of inpatients in private hospitals, this increase is about 1.8 times in public hospitals. Finally, another increase has occurred in bed occupancy rates. The bed occupancy rates in the hospitals affiliated to the MoH has increased from 60.6% to 68% from 2002 to 2018, this ratio has increased from 32% to 61.8% for private hospitals for the same period (Ministry of Health, 2018).

These figures evidence that the demand for private hospitals increased since the introduction of the HTP. However, the satisfaction rate with the services of healthcare providers offers an interesting picture. The rate of satisfaction with the services of private hospitals decreased from 65% in 2009 to 57% in 2018. However, the rate of satisfaction with the services of public hospitals increased from 66.5% in 2009 to 72.6% in 2018 (Ministry of Health, 2018).

To summarize, with HTP, health and pension funds have been separated, social health insurance schemes have been brought together under GSS and citizens' participation to GSS has been made compulsory. SGK has been established as the single-payer. At the same time, SGK has started to purchase services from the private providers that citizens can benefit from. While the reform has kept the SHI model intact, it has clearly introduced OOP and PHI as complementary healthcare financing mechanisms. Administrative figures indicate that the reform has made the private healthcare services more attractive for patients and the private health sector has increased its role within the new healthcare system.

3.2 Conclusion

This chapter demonstrates that the private health sector is a rapidly growing market in Turkey. The 2003 reform is one of the key drivers behind this growth. On the one hand, healthcare system reforms have increased the role of and demand for private health services. On the other hand, the collaboration between the public and private sectors and incentives (such as tax incentives and additional payments) for the use of private services and insurance might have paved the way for citizens' increasing reliance on the private sector. While the existing literature on the Turkish case have generally focused on the HTP's influence on the provision dimension, the HTP also

led to serious changes in the field of financing side. This thesis will contribute to the existing literature on the impact of the reform on the Turkish healthcare system by focusing on its relatively understudied dimension: financing.

CHAPTER 4

FINDINGS

To explore the dynamics behind the increase in PHI uptake in Turkey in the context of the present compulsory social health insurance, I benefited from the descriptive analysis of administrative data and a small-scale qualitative research with insurance agents. For the first part, I used the data from various resources such as MoH, OECD and Insurance Information and Management Center (SAGMER). For the second part, I conducted seven interviews with insurance agents. During the interviews, I asked questions about how insurance agents interpret the increase in PHI uptake with the idea that the strategic position insurance agents have at the point of sales of the product may contain important insights for the increase in PHI uptakes. Therefore, the chapter sets the scene by digging into the dynamics of increase in PHI uptakes using the administrative data and continues with the qualitative analysis of insurance agent interviews to further explore the dynamics of such increase.

4.1 The growth of PHI sector in Turkey

The development of private health insurance in Turkey compared to the United States and countries in Europe are slower. It is known that the first PHI-like applications in the modern sense were put into service under the name of “sickness insurance”. For the first time in 1938, Anadolu Sigorta Inc. launched a coverage similar to sickness insurance for those involved in ship rescue operations. A similar practice was observed in 1976, when Başak Sigorta Inc. started to offer a group of health insurance for those who have an account at Ziraat Bank. During the 1980s, a

number of companies such as Şark Sigorta Inc., Halk Sigorta Inc., Genel Sigorta Inc. and Oyak Sigorta Inc. sold a variety of group health insurance policies (Güdük, 2019).

Throughout the 1980s, private health insurances were not recognized as a separate branch in the insurance industry but they were sold under accident insurance and life insurance schemes. In 1990, health insurance was defined as a separate branch of insurance (Republic of Turkey, 1990). In the mid-1990s when foreign partner companies started to offer private health insurance to their employees, the PHI sector in Turkey started to gain momentum. This momentum was accompanied by an increase in the number of organizations and hospitals providing private healthcare (Arık, 2010; Orhan, 2015).

Today, PHI policies can offer coverage for inpatient and outpatient services. Inpatient coverage provides financial protection for the costs of treatments that individuals, whether they have undergone surgery or have not operated, are hospitalized. Outpatient coverage covers insurance, which offers financial protection for the costs of examination, diagnosis and minor medical interventions. Apart from these two types of insurance policies, individuals can also have insurance coverage that covers the expenses of medical treatment and tools such as dental treatment and optical glasses by paying an extra premium (Türkiye Sigorta Birliği, n.d.).

It is obliged for all local and foreign companies in the insurance sector to be a member of the Insurance Association of Turkey (*Türkiye Sigorta Birliği*, TSB). Established by law, this institution conducts research about services and activities of insurance companies operating in Turkey and is engaged in training and promotional activities. In addition to that, Article 24 of the Insurance Law No 5684 entered into force on June 14, 2007, has given the institution the status of a professional

organization with public institution status established in order to develop the insurance profession, provide solidarity among companies and prevent unfair competition (Republic of Turkey, 2007).

There are institutions with legal personality within the body of TSB. One of the institutions among these institutions is the Insurance Information and Monitoring Center (*Sigorta Bilgi ve Gözetim Merkezi*, SBM). This center was founded to gather data on insurers and insured (Sigorta Bilgi ve Gözetim Merkezi, n.d.). Here are sub-information centers that collect information and data about various types of insurance connected to this information center. Private Health Insurance Information and Monitoring Center (*Sağlık Sigortaları Bilgi ve Gözetim Merkezi*, SAGMER) is one of these sub-information centers (Sigorta Bilgi ve Gözetim Merkezi, n.d.).

SAGMER has an important database containing research and statistics about PHI. According to SAGMER database, PHI in Turkey is a rapidly developing sector. While the increase in insurance types in non-life branches was 23.3% in 2013, the increase in health insurance branch type was 10.5%, these rates increased by 2018, with an increase in insurance types in the health branch to be 24.4% and the amount of increase in non-life insurances to be 19.6%. In other words, this increase in the health branch, including PHIs, indicates a remarkable demand when compared with the types of insurance in non-life branches. When we look at the renewal type of PHI policies purchased as individual or group by years, 72% of group policies were renewed in 2019, 47.7% of individual policies; and 26% of group policies and 25.8% of individual policies were newly purchased. While renewal rates of supplementary PHIs are 44.9% for group policies, and 30.4% for individual policies; the ratio of newly purchased supplementary PHIs are 54.8% for group policies and 69.1% for individual policies. When we look at these rates, we see that a significant part of the

policies sold is composed of newly purchased policies (Sigorta Bilgi ve Gözetim Merkezi, 2019).

The number of PHI holders increased from 524.277 in 2008 to 2.502.672 in 2019. With the launch of supplementary PHIs in 2011, there seems to be a rapid increase in insurance sales, such that, supplementary PHIs with an insured number of 95.000 in 2011 increased to 921.118 with an increase of approximately 9,7 times until 2019 (Sigorta Bilgi ve Gözetim Merkezi, 2015; Sigorta Bilgi ve Gözetim Merkezi, 2019). Accordingly, in 2019, the number of people with private health insurance reached 3.423.790 in total (including both PHIs, and supplementary PHIs).

When we consider the distribution of the number of insured sold by product group and policy type, it appears that 1,086,907 of the policies sold are individual and 1,415,765 are group purchases in 2019. In supplementary PHIs, 482,527 are individual and 438,591 are group purchases. It can be argued by looking at these numbers that although individual and group purchases have almost close amounts, we see that individual purchases for supplementary PHIs and group purchases for PHIs stand out as prominent policy types (Sigorta Bilgi ve Gözetim Merkezi, 2019). Based on the data, it can be argued that although the growth of the PHI sector was predominantly group policy in the past, individual sales are now becoming more popular.

OECD's data also confirms the increase in the membership of PHIs in Turkey. Until 2003 when HTP started to be implemented, the coverage rate of PHI compared to the total population was at 1%. From 2003 to 2016, this rate has increased steadily. Especially since 2011, when supplementary PHIs were introduced, there was a significant increase in the coverage rate of PHIs compared to

the population, and as a result, total PHI coverage rates in Turkey reached 7.6% in 2016 (OECD, n.d.).

Concerning the distribution of the number of individual health insurance policies sold by 2019, we see that most policies are sold in Istanbul. Istanbul is the country's most populous province of Turkey and also most important economic center. However, the share of PHI members in Istanbul to those in Turkey exceeds the share of population in Istanbul compared to the population of Turkey. In other words, Istanbul residents are overrepresented among the PHI members in Turkey (Sigorta Bilgi ve Gözetim Merkezi, 2019). Finally, it is essential to mention the important role of insurance agents. Insurance agents are the units where individual standard PHI and individual supplementary PHI products are most sold (respectively 90.07% and 68.3% of these products are sold by insurance agents) (Sigorta Bilgi ve Yönetim Merkezi, 2019).

4.2 The distinguishing characteristics of PHI

Insurance agents play an important role in individual PHI sales. They are usually the first units to whom individuals contact when they decide to take out PHI policy. To understand the perception of the agency owners about the product, the participants were asked about their ideas about the PHI product, the difference and importance of this product compared to other insurance products such as accident, car insurance or individual pension.

On the basis of the participants' statements, it can be argued that there are a number of factors that make PHI distinct from other products. These differences are related to a number of concepts used by the participants in the interviews. Especially the concepts of “risk” and “protection” are the key concepts used when expressing

the distinctive characteristics of the PHI product, especially compare to other insurance products. The risk was used by the participants as a phenomenon that indicates future health problems. For this reason, it should be noted that there was a certain difference between the protection provided by other types of insurance against risks and the protection provided by PHI. The issue of "health" was the basis of this difference:

> Because a person can't estimate the health risks, he/she will face throughout his life. What is the biggest risk of a vehicle? You crash your car, it becomes unusable, if the car is 200 TL it is 200 TL, if 300 TL it is 300 TL... However, there is no limit to the health expenses that an illness causes you to spend for years. You get cancer treatment for two years, you can spend 500 thousand TL, you can spend 1 million and you can pay it to an insurance company instead of paying it out of your pocket. (…) And this is very important, you get rid of the risk of selling your home, selling your car, going to your family and saying that I need money by having your health insurance... (Respondent 2, has 24 years of experience in the sector, owner of an insurance agency)

Psychological protection appears to be a factor that relieves the user against risks. According to the answers given, these risks may be related to pre-disease or disease. More clearly, as the participants stated, the reason that PHI users evaluate PHI as protection is related to PHIs' relieving factor against the anxieties of users. Insurance agents also note that the risk is not only perceived as an individual risk but a familial one:

> People consider health insurance a more sensitive issue. Health comes first after all. It is also for their families. Now when you consider, you think that my health is important and my child's, my relatives' health, and then my car, my home, my business and so on. Therefore, I do not know, PHI seems more attractive to me (then other insurance branches). (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

As stated above, “protecting the family” appears to be another important factor giving the PHIs distinctive characteristics.

The responses to the question of why individuals should buy private health insurance pointed out that private health insurance is a protection factor against the

psychological pressures that may be caused by the financial burdens that may occur during the treatment of any disease. More clearly, PHI is considered as a more important insurance product than other products by insurance agents. The reason for this is the importance of the moral support provided by the PHI product during periods of health problems. One participant stated as follows:

> Protection... And to me, there is another plus side (of PHI): moral support. When the person is already sick, she/he does not want to consider the monetary aspect of the treatment. You may also be treated with the best hospital, by best doctors, but you are already upset about some things while you are in disease psychology and you are in a fragile state of mind. How much does it cost, do we have the budget, can we afford, who can I ask for money? You do not want to get into this psychology. Therefore, the last time a person should think about the money is when one is sick. In my opinion, PHI is a kind of gift that one can bestow upon themselves. (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

As stated above, the insurance agent incorporates not only the risk of individuals not getting any treatment but also receiving the best treatment available into her explanation of the benefit of PHI product in Turkey. In parallel with this explanation, another participant stated that the state hospitals cannot provide trust to their users when they needed it most, therefore, people buy PHI, even by enforcing their budgets:

> Of course, there is a sense of trust that you feel, what we need most in the treatment is the sense of trust, and the current public hospitals cannot provide confidence both as an institution, as a service, as a doctor or as a form of treatment. That is why people buy PHI by forcing their budgets. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

Insurance agents suggest that the uncertainty and unpredictability of the costs that may arise in times of sickness require insurance solutions. One participant stated the specific characteristics of the need for healthcare as follows:

> Let's talk about the property insurance policy, for example... Everything is very clear. The value of my home, the value of the land... But the human is the thing you deal, there are so many things that are undefined, so uncertain... So, you can't bring very clear regulations here. Take this pandemic (COVID-19) as an example, you can't predict it! Because the insurance company in

> front of us is a commercial institution, not a public service, it is focused on making money. Focused on profit-making. (...) So you can't draw clear lines here, because it's about health. There are too many variables. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

One of the most important factors that distinguishes PHI from other insurance products is that the PHI provides protection against financial risks associated with health. According to the perception of the participants, the damage (or financial expense) that other insurance products provide protection is more easily measurable than the financial damage that health related damages may cause. Therefore, it is considered as a more difficult possibility to introduce regulations in terms of financial constraints on the problems arising from health problems to which PHI provide protection.

4.3 The attractiveness of selling PHI

In addition to the abovementioned factors that explain the attractiveness of PHI for consumers, the product is also attractive for insurance agents. One of the most important reasons why PHI product is attractive to insurance agents is that this product has high premium prices compared to other insurance products. The high premium prices mean that the commission value received by the agencies from this product is also higher. The most common answers given when participants were asked how important PHI is for them were related to its profitability for the insurance agency. Besides, participants often noted that this product comprises of around half of total sales of agencies. One of the participants expressed this as follows:

> Since I sell health insurance, PHI covers an average of 60% revenue. The rest are other elementary branches because the rate of earnings in health insurance is slightly higher than in other branches. It is a little higher in terms of the revenues that it brings... (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

Also, another factor that makes selling PHI attractive to agencies is related to the fact that the income earned from this product is generally continuous. Although the sale of the product is more difficult than other insurance products, the high rate of renewal in PHI makes this product attractive for agencies. One participant stated this situation as follows:

> You will make a lot of effort until you sell health insurance at first, but the customer who enters the health insurance system becomes a customer with a higher level of awareness. She/he wants to protect himself against risks. It does not cause us difficulties at times of renewal. While a person goes to five companies to sell another insurance product, there is no need for a similar effort for health insurance. … Our insured, who gets good service, usually renews private health insurance. (Respondent 2, has 24 years of experience in the sector, owner of an insurance agency)

As can be understood from the quote, ensuring customer satisfaction seems to be an essential element for the insurance agents to have regular revenues from the renewal of PHI. Knowing the business well is another factor that makes selling PHI attractive to agencies. Agency owners generally stated that they have established their agencies after gaining experience in the insurance industry. Especially the participants who mainly work in the PHI branch in their previous work experiences preferred to go on developing their portfolios in PHI after establishing their agencies. This decision is explained in reference to the expertise gained in PHI. Participants often combined knowing the job with loving the job in explaining why they prefer selling PHI. One participant stated this as follows:

> For example... You know the group of friends... The people with whom I enter and quit the insurance company... We started to work in this center, we had a portfolio in X company, after a while, our portfolio grew and so on... We established our own agencies... All of that group of friends works on health insurance, our names are always mentioned as health-focused agencies ... There are many reasons. If you started in a company working on health insurance, you know the product well, you are very well aware of the product, so you lean to it. (…) Does it provide additional income? Yes, it does. But you are more successful in the job you know well. They say you should do what you love. So... It really works like that. (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

According to the participant's statement, it can be argued that making a profit is undoubtedly an important factor that attracts insurance agents to PHI. However, the fact that they feel competent in selling PHI is also an additional factor that motivates them.

Sometimes the reason behind loving the job of selling PHI lies in the fact that PHI products are different from other insurance products. It was stated that the distinctiveness of PHI is associated with its link to health in some interviews and in this direction, it is considered as a way of establishing more direct human contact with people. For example, one participant stated:

> There is an element of touching a person in health insurance, so I always liked PHI. … You will hear this sentence from most of the health insurers... If they really trust their product, … it's not just like claiming something you don't believe in... It is a job that we do sincerely... (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

In this quote, it is clearly evaluated that selling PHI product is a more humane part of working as an insurance agent. First and foremost, trust emerges as an important factor to increase the sales through person-to-person recommendations, as is going to be detailed in the third section of this chapter. At the point when the insurance agent provides trust to the insured, it also opens the potential for gaining new customers in line with the recommendations of its customers to other people they know. One of the participants expressed the importance of this issue as follows:

> As information technologies progress, we are now in contact with people mostly through referrals rather than face-to-face promotion. The logic of insurance is all about trust. So we work with you today, if you are satisfied, you recommend us to your contacts, and we continue to work with that person. (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

For example, it is stated that some sales techniques that can operate in other insurance branches are not preferred at the point of sale of PHI policies. The basis of this lies in the element of trust required specifically in purchasing a PHI policy:

> The portfolios of the agencies are based on the person to person recommendation. In other words, let me say that our customer portfolios are 60%, perhaps 70%, coming from the reference. The rest are called "sellers outside" who work in the field. There are people who work with the agency but try to sell insurance outside. They are the middleman. So, for example, I am an agent, I employ three or four men, they work on performance-based premiums, they do not work with a salary, or they work with a very low base salary. This is how a group of companies work, about 40% of them. They go to people, here I come from x insurance, and they act like I want to help with your insurance. Those who do this are generally those who sell pensions, those who provide services in branches such as life insurance. After all, you sell trust, nobody wants to trust and buy PHI from a street passer.

Trust is also expressed as an element that must be established continuously in the case of agents' relations with PHI holders. For this reason, it emerges as an element that affects other in-company works about the PHI such as the follow-up services to be completed and continuous contact kept with the customers. When one participant is asked about his responsibilities in the company, he expresses this situation as follows:

> I also go to the customer visits myself. So the customer is always connected with me, no matter if he is new or old. Even if I am not in the office, they know that I am supervising what to do when I return here. As soon as you break close contact with the customer, she/he surely shifts to a new agency. (Respondent 2, has 24 years of experience in the sector, owner of an insurance agency)

Trust is also expressed as the basic element that must be provided to customers to become a successful insurer. Because the provision of trust is an important factor for the renewal of the insurance, and it also means ensuring the continuity of the profit for the agency. Another participant answered the question of how a successful PHI seller should be like as follows:

> When you try to do it honestly... Because there is this group of people... I mean, yes, everyone works for money... But if you start to progress merely in

> this logic, you will not go with firm steps. For instance, when we started, we were a very small business. We put a policy, put another policy on it... I mean when you go with firm steps... Because the purpose is not to save the day. Let's say that I made a policy for you, for like 1 year, we made it this year, we cannot just say that the next year will take care of itself... But if you assure the customer, if you provide the service right, this bond will continue for years. Plus, let's say I made an insurance for you, you trust me (...) and tomorrow or some other day you will recommend me to your friend. You know, this business doesn't function alone. Huh, there is no such thing "like I'd find someone on streets"... (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

Similarly, a participant also suggested that trust is an important determinant of the agency's relationship with customers, which should be fostered in continuous contact. He noted:

> It is very important to provide good service, to get a good job done, and to establish a trust relationship. Therefore, you should not exceed your portfolio capacity so that you can give confidence, offer a good service to each and every customer. Because it is essential to follow-up things well. (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

The relationship of trust appears to be a factor that affects many issues, from business planning of agents to how to build a relationship with customers. In the final analysis, it can be claimed that the building of trust relationship with the customer affects the income of insurance agents through customer satisfaction. In other words, trust is an important form of informal relationship feature that must be built and protected for the PHI sector. In addition, the PHI sector's reliance on the referral marketing further increases the insurance agencies' need to create and sustain trust. In fact, all participants express this sales technique as the most important element of the expansion of their portfolio. One of the participants stated as follows:

> They hear PHI from around, it's a huge reference chain. The customer says I am very pleased, none of my requests is being rejected they say... They ask that is there any agent you know? They say, yes, there is… And direct this potential customer to me. (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

The participants stated that they tried different sales techniques besides referral marketing only in the first years they entered the sector. These are techniques such as marketing to those whose are insurance agents' acquaintances and cross-selling meaning that the marketing of the PHI product to the customers that they already sold insurance product in other branches. One participant explained this as follows:

> I never had a special marketing system. I always started with my closest circle. Then I asked if you have health insurance for those who have car insurance which means I tried to cross-sell... As I said, if I sell a car insurance to someone, I asked them "Oh, do you have health insurance?" We progressed so slowly. In other words, I have never adopted a sales technique like telemarketing or tried to sell PHI to someone I do not know... I always had a connection with the ones whom I sold PHI insurance. But can't be any other marketing strategies? Of course, they can. But our sales were not made to the people we don't know much. But for example, I know you, you have health insurance bought from me, you give my phone to your cousin... And it goes like that... (Respondent 2, has 24 years of experience in the sector, owner of an insurance agency)

Only one participant (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency) stated that they used the telemarketing method to increase their PHI policy sales in the first years of entering the sector, and after the portfolio reached a certain threshold, they switched into referral marketing. Among the reasons why insurance agents do not adopt an aggressive sales strategy to expand their portfolios is the fact that following up the existing portfolios requires a serious amount of time. In other words, the high rate of renewal of PHI policies and regular income opportunities coming from the renewal to insurance agents make these agents prefer to follow a strategy to satisfy their existing customers instead of spending their energy to find a new customer. The agents consider it more advantageous for them to spend the time to ensure the satisfaction of existing customers from the services agents provides. Participant 4 expresses this as follows:

> When you sell a PHI policy, new people are automatically directed to you when this is heard in the social network of the person you sold the insurance. And instead of reaching 10 customers and selling insurance to 1 of them, 1

> customer is already coming to me. I give the effort I have to spend to reach those 10 customers to my existing policies. I actually spend my time on them. But the form of sales in health insurance is the most detailed, so it takes a lot of time, especially the first year we sell it to the customer. The following years are much guaranteed for many agencies. Because the PHI customer renews its policy. So, it is not like they buy it this year and give up the next year. Unless there is a very extraordinary situation in that policy, that policy continues. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

As can be understood from the quote, establishing a trust relationship with existing customers is an advantage in terms of revenue for agencies, not only because of the possibility of renewal of the product, but also because it allows agents to expand their customer base.

Given the specific characteristics of the PHI product and the dominance of referral marketing in the PHI market discussed in this section, this section indicates that buying and selling a PHI product is built upon a personalized trust relationship between the customer and the insurance agency. This particular characteristics of trust relationship between insurance agents and PHI holders is noteworthy in understanding the dynamics of increase in PHI uptake in Turkey. Provided that a significant portion of new PHI purchases were individual purchases as discussed earlier in this chapter, this section implies that these purchases possibly were made through personal contacts that newcomers had with previous PHI holders.

4.4 Insurance agent explanations for the increasing PHI uptakes

4.4.1 Insurance agent explanations for the increasing standard duplicate PHI uptakes

The fact that the agency is the key unit in individual PHI sales makes participant explanations valuable in exploring the factors behind the increase in PHI uptakes. First, the participants were asked if they observed an increase in the demand for PHI. All participants replied in the affirmative to this question proving that the select

insurance agents are not exceptionally situated in the city and are also subjected to the observed increase in the administrative figures. The participants were then asked about the reasons behind the increasing PHI uptakes. All participants pointed out more than one factor for the increase. All participants linked the increase in PHI memberships directly or indirectly to problems existing within the public healthcare system. Apart from these, the insurance agents explained the increasing uptakes in reference to the increased capacity and demand for private healthcare services after the reform.

4.4.1.1 Problems of the general health insurance and its service coverage

The problems of general health insurance and its service coverage have been evaluated as an important dynamic in the increase of PHI membership. The participants were first asked why they think a person should have a PHI in the Turkish context. If they voice criticisms of the public healthcare system, the participants were then asked how they elaborate on their criticisms. In response to this question, participants revealed their perceptions about different elements of the healthcare system. Factors such as shortages in doctors and hospital workers, negative service provider attitudes, long waiting times, inadequate medical technology in public providers, low hygiene conditions, and inadequate infrastructure were among the mentioned elements.

One participant who was asked about the reasons for the increase in PHI membership stated:

> It is related to the fact that people are now losing faith in the country's healthcare system. For example, I had a personal experience very recently. A tomography needs to be taken, the doctor said it was urgent, the date he gave me was 10 days later. For example, if I had not gone to another doctor and had not had that procedure done, I would have had a serious illness, which would have resulted in surgery. So, people don't want to be at risk.

> (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

When asked about the reasons for people buying PHI, another participant addressed many factors from long waiting times in public hospitals to accessing competent doctors and the attitude that users encounter:

> In the public healthcare system, that is, in the facilities provided by the state, people have become aware of the current conditions more or less... An MR is needed, for instance, they schedule it 2 months later. Now if the man has money, he buys private health insurance, gets his MR, and goes to the doctor. He cannot go to the doctor he wants, he has to see a general practitioner (in public hospitals). For instance, the man wants to go to a professor but then he has to go to a private hospital. In public hospitals doctors do not make patients' rounds, they leave them to their students or practitioners. There are a lot of professors in luxury private hospitals. If you have private health insurance and its coverage is sufficient, you will get your healthcare from the professor doctor very easily, the insurance company will pay your money, and you will go out. (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

The negative attitude of health workers that patients encounter in public providers was a recurring theme in the interviews of the participants. One of the participants pointed out the problem of the importance of informal relations in terms of access to services in public hospitals and stated as follows:

> Well, I think there are a lot of hustles and bustles in public hospitals. If you do not have any acquaintance, it is difficult to get an operation day, it is difficult to get good treatment there, but there is no such thing that everyone has an acquaintance. (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

When the main problems in Turkey's public healthcare system were asked, the same participants related the problem of the negative attitudes of health workers that users encounter with other problems such as ill-pay and user density.

> I can say that a few things are very bad. Because the service providers are already very unhappy, unhappy with the money they receive, they are already weary of the number of people they serve. … I do not remember seeing a compassionate nurse in a (public) health sector. I mean, because when I went to the public hospital several times ... They are rather like unhappy people, sullen people, you do not feel you are cared even when taking blood from you... Of course, this is very sad. Normally every citizen should get a good

> service and be looked after. I do not think that this is a rare situation, there are many cases that patients are neglected and die. But these are all linked. How many patients can a doctor take care of? One should think about it. How many patients can a nurse take care of? What are their working hours? What is the share of these people in GNP compared to other countries? It's also about welfare. You should be happy to make people happy. (Respondent 2, has 24 years of experience in the sector, owner of an insurance agency)

4.1.1.2 Increased capacity of and demand for private healthcare services

Participants explained the increased demand for PHI as a derivative of increased demand for private healthcare services. There are various reasons for the increased demand for private hospital services. One of the reasons pointed out by the participants is the use of high-quality medical products in private hospitals. One of the participants explained that the users started to prefer the private hospital services instead of the services available in the public healthcare system as follows:

> You will undergo surgery in the public hospital, for instance, the doctor says, okay but this medical product is better, but the SGK does not reimburse this, it only reimburses this (another) product, but I am in favor of using it. You buy it, and give it to the doctor in the public hospital. There's no such thing in private hospitals, they always use the best product. But they get its return. There will always be a difference between public and private hospitals. If the state develops itself for like one level, the private develops itself five levels... They have power. (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

As can be seen from the above quotation he perceives private sector as of high quality and using cutting-edge medical technology which he thinks could be one of the reasons behind the increasing PHI uptakes.

All of the factors mentioned under the previous section namely the problems in general health insurance coverage and public healthcare services are claimed to ultimately turn PHI from luxury into a need for healthcare users. The main reason for this was explained by the participants regarding the claim that PHI provides

protection against financial risks that may arise in the context of increased private hospital services as follows:

> Once, when I started selling PHI, this product was more luxurious. Consciousness was not so widespread, there were not so many private hospitals... As time went on, health insurance started to become a need. There are many reasons for this. When you look at the fact that users do not get a good service from Social Security Institution's (SSI) public hospitals, as the number of private hospitals has increased and become widespread, as the quality of the services in private hospitals were experienced by people, they started to turn towards private facilities. As people increasingly started to benefit from these facilities, the demand for private health insurance has also increased. It turns into a need now. (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

The same participant also stated that buying a PHI has become a prerequisite in the context of increased private provision of healthcare:

> There is a horrible difference when you get this service from private health insurance or directly in a private hospital. What happens in one (when you have PHI) is 8 thousand TL, and the other goes up to 88 thousand TL. You say that what kind of a gap is this?! Everything is so unbalanced. So, people are buying private health insurance, if possible, in order not to be in an indecisive situation like whether should I go to this or there... (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

According to the perception of insurance agents, the desire to benefit from private health services through PHI is not only related to the factors mentioned above such as financial protection or increase in the capacity of private health services. In other words, the reason why private health insurance is an attractive product for users today in Turkey is not only the healthcare services it provides access. People's preferences of private hospitals as luxury and comfortable service provision settings was one of the factors that stands out as the reason for the purchasing of private health insurance. When participants were asked about the problems in the public health system one participant stated this factor as follows:

> There is also a hotel service. But I also think that it has been exaggerated a little more than it should have been. I don't know if you went to Y private hospital, there is no such magnificence and luxury anywhere in the world. …

> This has turned into a competition (between private hospitals)... (Respondent 2, has 24 years of experience in the sector, owner of an insurance agency)

Apart from the fact that private hospitals provide luxury hotel services, there is another factor that makes PHI attractive to users: privilege. According to some of the participants, although the users have the power to afford the high costs of the private hospital, they consider it a privilege to enter the hospital with PHI. A participant who asked whether there are any other motivations other than health behind the purchases of PHI stated the following:

> They (patients) consider it a privilege. They also buy PHI because they want to have a privileged product. Because, frankly, someone who can pay 15 thousand TL of PHI annually is usually someone who can also pay an annual health expenditure of 30 thousand TL for their family. … There is a privilege side to this purchasing (of PHI). When they submit to the private hospital, they enjoy the privilege of showing their health insurance card. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

The participant points out that some users consider having PHI not only because of some access- or healthcare expenditure-related concerns, but also sometimes as a social status indicator. Therefore, he indicates that some users may prefer to have PHI, although their economic conditions are good enough to meet private hospital costs out of pocket.

4.4.2 Insurance agent explanations for the increasing supplementary PHI uptake

Standard duplicate PHI and supplementary PHI have a number of differences in terms of provision and financing. When the participants compared PHI and supplementary PHI, without any exception they considered the PHI product as a more advantageous product for the user. The main differences between standard duplicate PHI and supplementary PHI are as follows: (1) Standard duplicate PHI is a type of insurance in which healthcare expenses are covered to a certain extent within the coverage and the rest is completed with additional payments. For supplementary

PHI, as the users are financially protected against additional payments that may arise while benefiting from healthcare services in private hospitals contracted with SGK, they are not subject to any additional payments, as long as they are adhered to contracted hospitals, (2) PHI product can also be used without SGK coverage, but for supplementary PHI, users should be covered by SGK, (3) The opportunities provided by PHI can be quite wide, according to the preference of the user, especially in terms of the hospitals to be utilized and healthcare services abroad. In the case of supplementary PHI, the private hospitals to be benefited are also limited within the scope of SGK contracts.

Participants have different perceptions of supplementary PHI. While some participants evaluate supplementary PHIs positively for the PHI sector, some consider this product as an element that undermines the sector. The main reason why supplementary PHI is considered as a harmful product for the sector was stated as the fact that this product offers limited service coverage defined by the SSI regulations. Also, unlike the standard duplicate PHI product, it was stated that the lifetime renewal guarantee is either not provided or that more years of contribution are required to gain such guarantee for the supplementary PHI products. Any disease that individuals may suffer until this right is acquired may result in not being covered with those diseases by insurance companies since to be entitled to acquire life-time renewal guarantee is harder for the supplementary PHIs. From that point of view, some participants evaluated this product as ineffective for the users and the sector. Besides, although both the supplementary and standard duplicate PHIs basically provide protection against financial risks that healthcare services users, these two products are considered as completely different products by insurance companies. In

addition, these policies are not reversible, meaning that, if a supplementary PHI purchaser decides to switch to standard PHI, they have to waive their acquired rights. One of the participants evaluated the launch of supplementary PHI negatively expressed his rationale as follows:

> The supplementary PHI policy is not a product that I like very much. The current situation is the shortage of the hospital network... So, every insurance company works with certain hospitals and you cannot go to any hospital other than them. For example, I witnessed following example, a mother took her child to the hospital, the child had an adenoid surgery in Z Hospital, the supplementary PHI was on, there is a stenosis in the trachea caused by adenoid surgery, and there are two different doctors who do these operations, one of them in H hospital and the other doctor was in P hospital. However, the supplementary PHI policy did not include those two hospitals. Therefore, the cost of one of the operations is not covered. In addition to that, when they want to switch to standard health insurance next year, that disease will be excluded from the new policy. In other words, if the same family had received a standard health policy instead of the supplementary one at the first stage, they would also benefit from their insurance for both operations as it is an ongoing treatment. That's why I mostly recommend standard PHI, an inpatient treatment package, which includes good hospitals. Frankly, I try to convince the customer as much as I can to the standard PHI instead of the supplementary one. I am obliged to sell the supplementary PHI to customers that I could not convince, but not because I love this product and trust it. Because they will buy that product eventually, so there is nothing I can do. However, in the case you experience an illness, the standard PHI functions better compared to the supplementary. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

The limited choice of hospitals in the supplementary PHI can cause various problems according to the statements of the participant. As exemplified by the participant above, the fact that a patient had to receive services from different hospitals for two interrelated operations created unexpected costs for the patient. Based on this case, the participant finds the standard PHI is interpreted as a more functional product.

Despite a few insurance agents evaluated the supplementary PHI negatively, the majority of the participants evaluated the supplementary PHI as a useful product for the insurance sector. First, all of the participants evaluated that conventionally the customer group who purchased the standard PHI are upper-middle or upper-class

individuals. However, they suggested that the introduction of the supplementary PHI product expanded their customer base. Almost all of the participants stated that with the introduction of the supplementary PHI, the customer group started to be more diverse in the sense of income groups. Different participants have expressed two positive implications of this development. The first is that the supplementary PHI product revitalized the PHI market in the face of increasing standard duplicate PHI premium prices. The second is that customers entering the PHI system with the supplementary PHI are considered to be prospective clients for standard PHI. In other words, most insurance agents perceive supplementary PHI membership as a gateway to standard duplicate PHI membership.

A participant who was asked about his opinions about the supplementary PHI expressed the positive aspects of the product mentioned above as follows:

> On the bright side, the product (PHI) has spread to the base, and it has become easier for insurance companies to sell products, to expand the customer pool. They need to expand the pool. The supplementary PHI has worked very well for the sector, PHI customer pool has expanded, it has brought new customers. It breathed new life into the sector. What does a new customer mean? Those who buy the supplementary PHI today will purchase the standard PHI or some other product the other day. (Respondent 5, has 8 years of experience in the sector, owner of an insurance agency)

All of the participants whose opinions about the supplementary PHI were asked brought similar explanations for the increasing memberships of the supplementary PHI. The factors that are the basis for this increase are similar to some factors that cause an increase in standard PHI memberships (dissatisfaction with public healthcare services, the comfort provided by private hospitals, etc.). However, regardless of these factors, the most important explanation for the increase of the supplementary PHI is that this product is an economically more accessible product. As mentioned above, the customer profile is more diverse than the standard PHI and the supplementary PHI is expressed as a product that appeals to the middle class

more. Besides, some customers who want to buy standard PHI are claimed to decide to buy the supplementary PHI when they find the prices of the standard PHI high. The fact that the supplementary PHI is an economically more accessible product has enabled PHI to be recognized by a wider customer constituency over the years. While the participants explained this product to the customers themselves in the first years when this product was launched, they stated that the demand is coming directly from the customers in the recent years.

4.5 Insurance agent perspectives on the problems of PHI in Turkey

Problems in the public healthcare system constituted a significant part of the participants' explanations regarding the increase in their PHI membership. However, according to the participants, the PHI system is not without problems either. The participants were asked about their ideas about the problems in the PHI system to better understand the current functioning of the private health insurance system. PHI system includes a wide variety of institutions and actors such insurance companies, insurance agencies, banks, brokers, users, which works in collaboration with private hospitals. In the interviews, the participants pointed to various problems in these various branches. In this study, the problems related to the private health insurance system are grouped under 4 sections: problems associated with private hospitals, users, insurance companies, and insurance agencies. Finally, the recommendations of the insurance agents are presented as the last theme of this section.

4.5.1 Problems associated with private hospitals

The most frequently mentioned problem was those associated with private hospitals. The underlying causes of the problem were stated as the fact that private hospitals

put the patients of private health insurance to unnecessary medical tests and treatments to receive a higher amount of money. The most unfavorable effect of unnecessary tests and high-priced treatments is claimed to be the loss of customers due to high increases in premiums when users renew their PHI policy. One of the participants explained this situation as follows:

> Because there is a loophole about private hospitals... Costs are very high. This affects premiums, therefore also insurance companies. The state needs to control private hospitals in some way. It is high, very superfluous, exorbitant prices. They cost an examination for like 1500 TL just because they are private hospitals. Like, there is no such thing in normal circumstances. It is a high amount, 1500 TL for 10 minutes. 40% of this amount is doctors, which means the rest is a huge profit for hospitals. The government should prevent this because these exaggerated amounts affect the policies, therefore it affects our sales. (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

Another participant expressed the problem of patients undergoing unnecessary testing as follows:

> In fact, when you go there as an individual, you can get a much more discounted health service, but unfortunately, the bills can be inflated when you go through the insurance company. Unnecessary tests can be done. Of course, they have control systems within insurance companies, but as I said, you cannot prevent unnecessary testing. The insured says that my doctor needed, s/he demanded this, s/he demanded that. Is it really necessary or do they really direct users to undergo unnecessary medical testing just because they have PHI policy? Because unfortunately private hospitals have such an aim. Naturally, the premiums increase very much because these expenditures cannot be taken under control. (Respondent 2, has 24 years of experience in the sector, owner of an insurance agency)

In addition to the unnecessary tests, another dimension of the hospitals' alleged abuse of insurance companies was expressed as reporting of medical intervention differently to the insurance companies in order to receive higher amount of reimbursement. One participant stated this situation as follows:

> The real problem is in the hospital. Because hospitals consider insureds as a ready source of money. A person goes there saying s/he has a headache... It was like 15-20 days ago I guess... They (the doctor) demanded tomography for a 20 days old baby. I went on the rampage! How could you let them do this? They frightened the family so much so that they had to have their baby a

> tomography scan. The doctor said to them that there could be a problem with the brain or something, I have to demand that and so on... But the only aim was to make money from this insured. They do not care whether it is a baby. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

As can be understood from the quote, in this example, the patient with a PHI is actually transformed into a customer through which private hospitals gain profit rather than treating them as patients. Private providers use the informational asymmetry existing between them and the patient for the benefit of the private hospital.

4.5.2 Problems associated with PHI holders

PHI user behaviors was mentioned as one of the factors that cause problems in the PHI system. PHI companies normally do not cover the diseases and chronic diseases diagnosed before the customer takes out PHI. According to the participants, despite the possibility that the users may hide some of their illnesses, insurance companies set the waiting periods for some diseases in the first years when the insured enters the PHI system. One participant stated this situation as follows:

> People consider taking out PHI when they experience illness, however, even if they hide the previously diagnosed diseases they usually burst. The insurance company can recognize it. (...) Some hide their conditions. They may think they can make the insurance company pay for previously diagnosed diseases. But if they are insured the first time in their life, if they enter the system for the first time, in some cases, the insurance company may stipulate some exceptions in the policy, like waiting times for some diseases for the first 12 months of the policy. We present them to the insured because you have to get their signature. But they still can hide their diseases because we create policy based on the statements of the customers. However, when they go to a hospital, for example, they have to go under a medical examination, the doctor asks them their disease history briefly, like since when they have those symptoms, etc. Every information they give to the doctor is forwarded to the provision service at the general directorate of our insurance company. There are doctors in that unit as well, in every insurance company producing PHI. Therefore, if there are conflicts between the statements given before the purchasing of PHI policy and the examination conducted by doctors, the insurance company directly rejects to pay for those diseases. (…) So you have no possibility to hide anything. It will surely be

> out sooner or later, and the insurance company can either cancel the policy or stipulate an exception to the policy related to the disease they hide. (Respondent 1, has 27 years of experience in the sector, owner of an insurance agency)

One of the strategies that users develop to hide their illnesses from the insurance company is cooperating with doctors to register medical interventions differently to the insurance company. When asked about the problems brought by the regulations in the PHI system, a participant stated this situation as follows:

> A second part (of the problems) is the insured... The insured people also abuse the system. There are certain rules for being included in PHI. You should be healthy, you do not have a chronic disease, you must be in a certain age range and so on. A person may hide their diseases. Afterward, they demand doctors to state those illness like newly occurred conditions. They go under an appendicitis surgery and demand doctor to state this as cholecystostomy (to the insurance company). (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

Here is an example of a situation inherent to the PHI system that forces the user to adopt different strategies. It is seen that the user can resort to abuse the system in order to gain maximum benefit from the product (PHI) they bought.

4.5.3 Problems associated with insurance companies

The problems that the participants also include insurance companies' lack of responsiveness to their PHI holders. Some participants considered this situation as a negative aspect of the PHI sector. One participant expressed this situation as follows:

> On the other hand, the health insurance system does not behave very humanely. There was a woman who had cancer treatment. But she had her treatment in her country, and she had a foreign PHI policy either. She uses her foreign policy for her cancer treatment which has nothing to do with the policy she wants to take out here. She lives here because her husband lives here. But the insurance company knows about this cancer history. It was 2010, I guess... The whole family was paying on average 20 thousand TL in total. When she got cancer this year, the insurance company said that we are going to leave you out of the scope of the insurance. She was very hurt. She was very rightfully hurt. Think about it, you are trying to deal with a very serious health problem, and you are naturally very sensitive, and the insurance company does not consider you insurable. (...) You cannot leave a

> human being at the mercy of an institution that focuses merely on making money. As I said, you are a source of money for the insurance company. You are a unit producing premiums and there is no way they could behave you humanely. In any case, it will let you down. The person takes out the insurance now and will be cancer 6 months later... It is a very common example. Think about it, there is a cancer treatment started, 1 year later the company will let you down. Because there is no guarantee of renewal. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

The problem pointed out in this quote actually expresses the basic reality of the private health insurance sector: a system based on profit making. The participant actually makes a criticism of the fact that the sector is based on making profit.

4.5.4 Problems associated with insurance agents

To hide the previously occurred diseases of the insured, the agents also direct insured people to hide those diseases from the insurance company, as some interviews demonstrate. According to the interviews, the reason for this was associated with the desire of agents to increase their sales.

> Agents can also abuse. Let's say I am malicious; I can direct you to cheating. Doctors can recognize this from the user's disease history. Insurance companies can request information on the patient's disease from private hospitals. They have such rights. If they notice, they say stop. ... They (insured) tell me when they are insured at the beginning, like, I have this illness, I have this operation, and how can I hide it from the insurance company? ... Are you asking me? ... Our duty is to state the truth correctly so that the insurance company decides whether to insure a person or under what conditions. But what if I just abuse the system to sell policies? If the insurance company notices this, it will not cover it at least or cancel your policy. But what is actually done is the forgery of documents and there is no sanction. (Respondent 3, has 26 years of experience in the sector, owner of an insurance agency)

Another problem that was claimed about the insurance agencies in the interviews was that the agencies selling the product to the user without knowing the product well. As a result, this situation causes the dissatisfaction of users in the long term, the PHI sector is also damaged. One participant stated this situation as follows:

> But there is a problem in our sector, with respect to health insurance, especially agencies or brokers or banks are completely ignorant in terms of knowing the product ... Trying to sell the product without knowing it. They try to sell a product that they do not know enough. (Respondent 4, has 16 years of experience in the sector, owner of an insurance agency)

The participant claims that the insufficiency of the employees of the insurance agents about the product is considered to create future problems.

4.5.5 Insurance agent recommendations to improve PHI market in Turkey

When the participants were asked what kind of arrangements could be made to tackle the existing problems in the PHI system, the answers varied according to the problems that the participants focus on. For example, as a solution to the problem of private hospitals offering exorbitant prices, a participating suggested that the state should take more effective control.

Another solution proposal addressed by the participants points to inexperience and the lack of knowledge about the PHI product as the source of the problems, and a standard was proposed in sales channels. One participant stated this situation as follows:

> At the moment, it (the PHI) is sold everywhere, in fact, the bank, agency, broker, the company sells itself, the public bank sells, or sigortam.net... There is no standard here. There has to be a standard. Because the standard of each company is different. (…) First of all, they need to be experienced in the sales for this, they have to be in this sector. There are more than 15 thousand agencies in Turkey. Half of this doesn't even know the health insurance, it hasn't even sold one yet. All of them are agents that sell traffic-motor insurance. Now, when somebody goes and gets insurance from there, they have a problem two days later, because the seller doesn't know the system. Let's say you went to the hospital, say you said your complaint about a topic, whether this (the PHI) is valid because there are certain criteria in the end. For example, you do not even know whether your policy covers the expenses in a certain hospital... If the person who sells it now does not know about it, how can the customer solve the problem? Here, they have to call their provision, they have to take care of the problem. Now there are companies selling it (the PHI) online. The customer never even met them. For example, they bought it from sigortam.net, they have no counselor, they are likely to experience problems, it is not for a one-day product, it for a long-lasting. You

> need someone to take care of your problem, to tell you, to guide you. There must be someone you can call and ask. Currently, the situation is not all like that in the sector. Everyone sells, but no people are serving. (Respondent 5, has 8 years of experience in the sector, owner of an insurance agency)

The standardization proposal is actually considered as a solution proposal that points to all the information problems addressed by the participants.

4.6 Insurance agent perspectives on the role of PHI in the ideal healthcare system

To explore the aspirations of PHI agents, they were asked what the role of private health insurance would be in an ideal healthcare system. All participants, except two, gave quite similar answers to this question. The majority of these responses were that PHI would not be needed in an ideal healthcare system or PHI premium prices would decrease in such a system in which publicly provided healthcare services are adequate. The majority of the participants even evaluated this situation positively for the private health insurance sector. They claimed that, in such a scenario, private health insurance would also become widespread as premium prices would fall and the product would become accessible in terms of prices. At this point, the participants were asked what the difference between the services provided by the PHI and the public healthcare services in such a scenario could be, pointed to factors such as luxury, comfort, and privilege. In addition to these, most of the participants stated that they cannot imagine that a public healthcare system would ever become adequate. Therefore, in the end, they noted that there will always be a demand for PHI.

Two participants argued that the ideal system should be based on private health insurance. They argued that if the state withdraws from healthcare and/or promotes private health insurance membership, premium prices would fall so that PHI premiums would be lower than the premiums paid for social insurance,

accordingly, everyone would benefit from the "quality healthcare services offered by private hospitals". Participants who prefer a healthcare system based on PHI stated that they do not believe the financial sustainability of the social health insurance system. Besides advocating that social health insurance should be abolished, one of the participants argued that in the ideal system, the supplementary PHI would be promoted and popularized by the state.

4.7 Conclusion

The findings of this research provide a brief synopsis of the growth of PHI sector in Turkey and insights for increasing PHI uptakes from the viewpoint of insurance agents. All insurance agents participated in this research stated that they are the first persons contacting prospective clients, in addition, they are the ones who construct and uphold trust relationship with the clients. Therefore, I argue that their explanations provide a valuable interpretation for the dynamics leading to increased PHI uptakes.

First and foremost, the growth in the PHI market especially after 2010s is striking. While the PHI market was dependent upon group purchases by corporations in the past, a noticeable increase in the individual purchase of PHIs is noteworthy especially in the last couple of years. One contributing factor has been the introduction of supplementary PHIs that provide protection to healthcare users against the financial risks that additional payments in private hospitals may create. The individual purchase of standard PHIs (although the sale of group policies is still slightly more in this PHI type) are also worth noting.

Although Turkey is not exception to the trend of increasing uptake of PHI, factors specific to its healthcare system and social change leading to this

phenomenon have not been analyzed in the literature yet. Despite the fact that people's satisfaction with public services in healthcare has increased over the years in Turkey as discussed previous chapter, there is also a continuous increase in the membership of PHIs. For instance, the MoH statistics show that the majority is satisfied with the public providers, which creates a paradox in accounting for the increasing PHI uptake to be explained.

I first tried to understand the importance and meaning of the product for insurance agents. The answers given to the interview questions pointed to the difference of PHI product from other insurance products for insurance agents. As these differences are detailed above, these differences affect the perspective of insurance agents about the product, the relationships established with the customers who purchase the product, and, of course, the revenue of the insurance agents. The main reason why the PHI product is attractive to insurance agents is generally related to the fact that it provides a steady flow of profit that comes through renewals. However, in addition to this factor, the participants pointed to a number of features that made the product different. These differences seem to be related to the fact that the product provides more important protection to the users since it is related to health. This also affects insurance agents' perspectives on their job, as they were more fulfilled in selling PHIs given the social meaning they attach to this product.

Trust was expressed as an important factor in the relationship of insurance agents with the customer. Especially at the point of expanding the portfolio of insurance agents, the relationship of trust seems essential. So much so that, according to the participants' statements, the main driving force in the expansion of portfolios is claimed to be person-to-person recommendations. On the basis of these recommendations, customer satisfaction provided by the relationship of trust plays

an important role. In addition, it seems important to establish a relationship of trust in existing customers' renewal of their policies. However, as the analysis above suggests, once the profitability of the insurance company is at stake this trust relationship can be broken.

Participants were well aware of the increase in their PHI uptake. The analysis here shows that insurance agents do not need to adopt an aggressive marketing strategy. Increased demand for private healthcare services channels new people to insurance agents through person to person recommendation. They provided two key explanations regarding the increase in PHI uptakes. The first is related to problems in publicly provided healthcare services as part of the social health insurance and decreased customer satisfaction with publicly provided healthcare services. Among these problems are issues such as waiting-times, hygiene, negative attitude of health workers, and the transfer of quality physicians to the private healthcare sector. In addition to them, according to the perception of insurance agents, it can be argued that PHI product was often bought for reasons such as increased capacity of the private sector, higher quality of the medical products used in private providers as well as the demand of clients for luxury and privilege. Although similar factors were mentioned for the increases in supplementary PHI uptakes, it was stated that this product is an economically more accessible product. It can therefore be argued that the supplementary PHI customer base appeals to economically more diverse customer group.

Although the increase in the PHI were often associated with the problems in public healthcare system by the participants, they claimed that the PHI system also has some flaws. These problems were associated with different actors in the PHI system. Based on the findings of the research, it can be claimed that these problems

are generally related to different actors attempting to abuse the system. Users, private hospitals and insurance agencies may try to abuse the system with different motivations as detailed above. Users, for instance, may hide their illnesses in order to get cheaper premium pricing. According to the findings of the interviews, it is seen that insurance agencies can also abuse the system in terms of hiding or directing users to hide the diseases. On the other hand, it was claimed that hospitals may demand unnecessary treatments and testing from users to economically exploit insurance companies. It was stated that such situations may cause the cancellation of the policies of the users or an increase in the policy prices during or before the renewal periods. As a solution proposal to such problems, participants recommended the government to take more effective control of private healthcare providers, to standardize sales channels of PHI and to require insurance agencies to employ competent personnel in PHI sales who are knowledgeable about the product.

Finally, the perception of insurance agents about the ideal healthcare system was striking. Although all participants are critical of the current state of the public healthcare system, most of them argued that an ideal health system should be based on public financing, however they stated that they are hopeless about it to happen. In such a system, it was claimed that PHI would not be needed or could be served to wider populations since premium prices would decrease. On the other hand, very few participants argued that the ideal health system should be PHI-based and claimed that the state should withdraw from the healthcare system. In such a scenario, the participants claimed that the premium prices would be lower than the amount paid to the social insurance system and stated that they believe that the social health system is not financially sustainable.

CHAPTER 5

CONCLUSION

This thesis departed from a paradox: Why do private health insurance membership increase in a country that expanded its social health insurance to all its citizens? What are the dynamics behind this change? The aim of the present thesis was to examine the reasons behind increasing PHI uptakes in Turkey through a descriptive analysis of the administrative data and a small-scale qualitative study exploring the perspectives of the insurance agents. The thesis contributes to two streams of literature: the literature on PHI uptakes and the literature on the changes in the Turkish healthcare system. First, the existing literature exploring the factors leading to increase in PHI uptakes falls short of developing a convincing explanation for countries with strong public financing of healthcare including Turkey. To compensate, this thesis offers a contextually grounded explanation for increase in PHI uptakes in Turkey. Second, the existing literature on the changes in Turkish healthcare system often focuses on the provision side. In response, this thesis sheds light on the changes in the financing dimension after the 2003 reform.

In addition to the descriptive analysis of administrative data, this thesis relies on a qualitative study with insurance agents based in Istanbul. Given that the insurance insurance agents are usually the first people who encounter with the PHI customers, this thesis focus on their perspectives as a possible gateway through a more comprehensive explanation for the increase in PHI uptake in the Turkish case.

Healthcare system in Turkey relies on a compulsory social health insurance-based financing model, where PHI uptake is optional. Standard duplicate PHI was

available long before the 2003 reform, however, its uptake remained a luxury good for high income individuals and PHI holders constituted less than one per cent of the population. With the 2003 reform, the healthcare system of Turkey has undergone a serious transformation including the launch of the supplementary PHI. This transformation dramatically changed various aspects of the system including the financing side. Changes promulgated with the introduction of the reform had not only abolished previous fragmented structure of the social security system but also extended the beneficiary base with the introduction of a compulsory social health insurance. Hereby, on the one hand, the public financing characteristics of the healthcare system were reinforced and the share of public expenditures in healthcare increased in the early phase of the reform, on the other hand, reforms have also been criticized for the fact that contribution payments for publicly provided healthcare services would create income-based inequalities in access to healthcare (Yılmaz, 2020; Yılmaz, 2013; Ökem & Çakar, 2015; Yaşar & Uğurluoğlu; Yıldırım, Yıldırım & Erdem, 2011).

One of the developments as part of the 2003 reform is the incorporation of private healthcare services to the social health insurance, which allows people to benefit private hospitals through additional payments (co-insurance). As a result, over the course of the reform, there has been an increase in the amount of healthcare users benefiting from both public and private healthcare services. The introduction of floating additional payments for SGK-contracted private healthcare services was also subjected to criticism due to the reason that it creates again an income-based inequality in access to different healthcare providers since the income level is an important determinant of ability to pay the rising additional payments that private hospital charge (Yılmaz, 2020; Yılmaz, 2013).

The increased use of private healthcare services and the rising additional payments for SGK-contracted private healthcare services has affected the growth of the PHI sector in Turkey. One aspect of the growth in the private health sector is the increase in both standard duplicate and supplementary PHI memberships that this study demonstrates based on a descriptive analysis of the administrative data. One of the important consequences of increasing additional payments is the emergence of the need for supplementary PHIs, through which people can protect their income against the financial risk that may stem from additional payments in SGK-contracted private hospitals. The analysis here indicates that the introduction of supplementary PHI extended the base of PHI holders in Turkey. While the PHI was available in Turkey long before the reform, it only served less than one per cent of the total population. Therefore, the increase in private healthcare provision and its incorporation into the compulsory social health insurance have created the conditions for rising supplementary PHI uptake. In addition, my analysis based on available administrative data confirms that the supplementary PHIs have become a crucial factor behind the rising PHI uptakes as the data shared in Chapter 4 suggests. While sales of standard duplicate PHIs increased approximately 4.7 times from 2008 to 2019, sales of supplementary PHIs increased by 9.7 times from 2011 to 2019. In addition, the data indicate that the renewal rates of PHIs are high, therefore it can be claimed that the PHI sector is both growing and dynamic field of business.

My analysis suggests that there are some factors that make PHI product attractive for insurance agents. The most obvious finding is the fact that selling PHI is a profitable choice for insurance agents since the premium rates and the renewal rates are quite high in both group and individual policies (72% and 47% for 2019 data respectively) making this insurance product attractive for insurance agents. The

sale of this product, which brings higher premiums than other insurance products, provides higher revenues to agencies, while renewal rates make this revenue continuous and sustainable. My analysis suggests that the sustainability (in terms of revenue) and the profitability of PHI product is related to the trust-building role of insurance agents.

All of the participants stated that they are aware of the increase in PHI uptakes. How do insurance agencies explain the factors that caused the increase in PHI uptakes in Turkey in the context of expanding social health insurance coverage? The present thesis finds that insurance agents explain the rising PHI uptakes in reference to two main factors: PHI buyers' perceived problems in the publicly-provided healthcare services and PHI buyers' demand for private healthcare services that increased capacity with the HTP reform.

The most common explanation from the participants for this increase is the dissatisfaction of the users towards the publicly provided healthcare services. Issues such as waiting time, perceived hygiene conditions of public providers, negative attitudes of hospital staff towards users and transfer of successful physicians to private hospitals are among the main reasons for dissatisfaction of users regarding publicly provided healthcare services. Most of these findings seem to be consistent with previous studies on other country cases indicating the dissatisfaction of people with their publicly funded healthcare system (Aarbu, 2010; Besley, Hall, & Preston, 1999; King & Mossialos, 2000; Taylor-Gooby, 1986). In addition, insurance agents perceive that increasing private sector capacity and the use of high-quality medical products in the private health sector have increased the demand of the users for private hospital services.

Although the increase in demand for private hospitals is consistent with MoH's data, the explanation of decrease in user satisfaction with publicly-provided healthcare services contradicts the statistics of MoH. As shared in Chapter 3, according to the data of MoH, there has been an increase of 6 per cent in the satisfaction of users towards publicly provided healthcare services from 2009 to 2018. Conversely, it is observed that there is an 8 per cent decrease in the satisfaction of users towards private hospitals (Ministry of Health, 2018). The analysis based on insurance agent perspectives towards increase in PHI uptake points to the contrary, and indicates that increased demand for PHI is related to the dissatisfaction of a portion of society with publicly-provided healthcare services. Therefore, it can be argued, despite the overall increase in satisfaction with the publicly provided services, a growing portion of the society is relatively dissatisfied with these services and search for PHI alternatives to access healthcare services.

The perspective of insurance agents towards rising PHI uptake also includes some evaluations regarding the trust of their customers in the publicly-funded healthcare system. My analysis suggests that the statements of insurance agents point to PHI buyers' distrust in the publicly-funded healthcare system. While this distrust sometimes originates from real-life experiences with the public providers and associated dissatisfaction, it can well be rooted in negative perceptions of public providers that are not backed by experience. In the PHI case, people's distrust of public healthcare seems to induce them to use private healthcare services. In return, insurance agents play a key role in consoling users' trust in the PHI system by tapping into their distrust in the publicly-funded system.

As presented in Chapter 4, the majority of new PHI sales is individual contracts and goes through insurance agents as the main sales units. One

unanticipated finding of this research was that the insurance agencies do not adopt an aggressive sales strategy such as promotion or advertising in order to sell the PHI product. This does not mean that the marketing strategies of the PHI product is never adopted. Insurance companies may still be performing advertising and promotional activities (for example, through websites). However, insurance agents interviewed suggested that it is often the customers that approach them to purchase PHI through chain referral. They suggest that the trust relationship they built with their previous customers functions as a mediating factor for the sales of new PHI policies. This thesis argues that the trust relationship established by insurance agents with customers is a crucial factor for the growth of PHI's customer pool. In order to establish and maintain this trust relationship, it seems that insurance agents play a key role by developing a more personal relationship with their customers during and after the sale of the PHI product. Just as Arrow points out that trust relationship between the physician and the patient is based on social obligation, the trust relationship between insurance agent and users seems to be based on a social obligation as well that serves both parties. According to the statements of the participants, it can be claimed that person-to-person reference is an important driving force for the extension of the customer base of the agencies. In order to function the reference from person-to-person, the customer satisfaction and therefore the construction and continuity of the relationship of trust seems to be an important factor for insurance agents. In addition, since the protection of trust is an important factor in the renewal of users' policies, insurance agents are motivated to maintain this trust relationship.

I argue that the trust relationship between insurance agents and PHI holders points to an important problem with the PHI system. This problem is an asymmetric

information problem that Arrow emphasized, who was one of the first to criticize out of pocket financing of healthcare services (Arrow, 1963). I argue that asymmetric information occurs not only between the patient and the physician (although this is also the case) as Arrow pointed out, but also between user and the insurance agent as Vellekkal (2009) suggested. Depending on the statements of insurance agents, it can be argued that insurance agents have more information about numerous aspects of PHI policy schemes than prospective insurance buyers. This situation puts the customer in a position where clients are wide open to abuse at the purchasing stage of the policy (as it has the risk for the prospective clients not to be aware of all of the rights the policy provide), and as it was mentioned above, it requires the insurance agents' consultancy service in any problem encountered while benefitting services of private hospitals. However, this consulting service is problematic as it is built on an informal trust relationship. The construction and continuity of the trust relationship is based on the unequal power relationship established by the agency with the user, since the continuity of this trust relationship depends on the insurance agent's desire to continue although insurance agents are motivated for the continuity of the trust relationship.

Person-to-person recommendation, which is a return of trust relationship, seems to cause the insurance agent's customer group to be a more homogeneous group. As a matter of a fact, especially the customer group of standard duplicate PHIs claimed to consists of upper-middle income and high-income individuals. For the supplementary PHI, the customer group is more diverse in terms of their income, and was generally pointed to as a middle-income customer group by participants. More clearly, based on the fact that the person-to-person recommendation is the most important factor in the development of the customer base of the insurance agents, it

can be claimed that the customer group faced by the insurance agents generally comes from similar social class positions. Considering this, the dissatisfaction of PHI buyers towards publicly-provided healthcare services that insurance agents perceive may be that of middle- and high-income groups. I argue that the dissatisfaction of these user groups from the publicly provided healthcare service can pose a danger to the political sustainability of the publicly funded healthcare system in the long run. In other words, in the long term, there may be a decrease in the support of these groups for publicly financed healthcare system. I argue that this possibility most endangers the right to health of low-income groups, who cannot benefit from private healthcare and paves the way for a healthcare system in which income-based inequalities are deepened.

If my suggestion is correct, it also implies deepened stratification in accessing the healthcare system. Discussions in the literature on Turkey point out a number of factors that exist in the healthcare system and are implemented with HTP, such as contributory payments for publicly provided services, a largely remained employment-based system and additional payments for SGK-contracted private services, which together create income-based inequality in access to public healthcare services (Ökem & Çakar, 2015; Yaşar & Uğurluoğlu, 2011; Yıldırım, Yıldırım & Erdem, 2011; Yılmaz, 2013). Increasing PHI uptakes also point to a different dimension of this stratification.

I believe that the perspectives of insurance agents on the ideal healthcare system analyzed in this study shows the benefits of a contextually grounded approach. One might assume that insurance agents have a bias against the publicly-financed healthcare due to the sector in which they work. However, when asked about what kind of function PHI should have in the ideal health system, insurance

agents gave surprising answers: most think that the ideal health system should be publicly-financed. I argue that this point of view actually points to the core meaning of PHI for insurance agents in the context of Turkey. Despite the increasing PHI uptakes, almost all insurance agents consider PHI as a complementary or luxury consumer product in an ideal healthcare system. As a matter of fact, it can be claimed that many of the problems they claim regarding the PHI system are related to problems that exist or may exist (e.g. informational asymmetry problem) in a profit-oriented healthcare system.

To conclude, this study offers an alternative explanation to the rising PHI uptakes in Turkey. I believe it is important to examine the increased PHI uptakes in a country where healthcare is practically publicly-funded. Analysis of the research findings shows that insurance agents are based on the trust relationship established with the customer in their goals in increasing their revenues rather than adopting an aggressive sales strategy. Insurance agents' explanations for the increase in PHI uptakes indicate that user satisfaction with the publicly provided healthcare system is open to a more complex assessment than it seems. The 2003 reform incentivizes users, especially those with sufficient economic conditions, to benefit from private healthcare providers. This may be one of the main driving forces of the increase in PHI uptakes, and the statements of insurance agents support this finding. Therefore, it can be argued that the increase in PHI uptakes actually reflects another aspect of stratification in access to healthcare. On the other hand, as detailed above, some of the criticisms in the literature regarding the provision of healthcare by the market forces are in line with the perception of insurance agents regarding the problems in the PHI system. I argue that inequalities in access to healthcare services are damaging for the public-based and inclusive features of the Turkish healthcare

system in the long run. Problems that are pointed by insurance agents as currently exist in the PHI system may deepen the problems faced by healthcare users while benefiting from healthcare services when these inequalities deepen.

Finally, it is necessary to mention certain limitations of this study. First of all, this research is based on perceptions of insurance agents. In order to enrich the debates on rising PHI uptakes, qualitative studies that present the experiences of healthcare users are necessary for in-depth analysis of the issues that this study deals with. Finally, the field of this research is limited to the city of Istanbul, where private hospitals are concentrated, have high PHI membership rates, and therefore can be considered as an important area for the private health sector. The perceived reasons for the increase in PHI uptakes may vary in other cities.

APPENDIX A

SEMI-STRUCTURED INTERVIEW QUESTIONS

1) How long have you been in the insurance industry? Can you tell me a little about your working experience?
2) How much part does PHI constitute your work? How important is health insurance for you compared to other types of insurance?
3) Could you tell me a bit about the job description of your position in the company and the responsibilities it brings to you? For example, what is expected from a successful private health insurer?
4) Do you have a specific target group to sell private health insurance? How much can you determine the target group you want to sell the product as an agent? How much the company priorities are important?
5) Through which channels do you reach the individuals you want to sell private health insurance (Telephone, face to face etc.)?
6) Do you have a standard sales strategy when talking to the people you contact to sell private health insurance?
7) What do you think are the reasons for people take out private health insurance?
    a. What do you think are the reasons for people not to take out private health insurance?
    b. What kind of counter-arguments do people often tell you about the private health insurance product? How do you respond to these arguments?

8) What do you think are the problems existing in Turkish healthcare system? What is the function of private health insurance in this context?
9) If we take into consideration Turkish healthcare system, what does private health insurance offer that is not provided by this system?
10) In what ways do you think the function of supplementary private health insurance and standard private health insurance is similar? In what ways are they different? How do you separate these two products from each other when you tell someone who consults you?
11) Would you tell supplementary health insurance and standard private health insurance to people with different characteristics? Or would you tell both of the people who are thinking of taking out health insurance? Why?
12) Private health insurance sector in Turkey subject to certain statutory provisions, as well as in other countries. Are there any factors that cause disruptions in the private health insurance system within these regulations? Or is there any lack of these regulations?
    a. In your opinion, what kind of regulations can be introduced to improve the private health insurance sector?
13) What kind of function should private health insurance have for you in an ideal healthcare system? Should it be a private health insurance-based system? Should private health insurance be supplementary? Why?

APPENDIX B

SEMI-STRUCTURED INTERVIEW QUESTIONS (TURKISH)

1) Ne kadar zamandır sigortacılık sektöründesiniz? Çalışma deneyiminizden bana biraz söz edebilir misiniz?
2) Sağlık sigortacılığı işinizin ne kadarlık bir bölümünü kapsıyor? Diğer sigorta türleriyle kıyasladığınızda sağlık sigortası sizin için ne kadar önemli bir ürün?
3) Peki, sizin şirketteki pozisyonunuzun görev tanımı ve size getirdiği sorumluluklardan biraz bahsedebilir misiniz? Örneğin başarılı bir özel sağlık sigortacısından beklenen nedir?
4) Özel sağlık sigortası satmak amacıyla belirli bir hedef kitleniz mevcut mu? Ulaşmak istediğiniz hedef kitleyi acente olarak siz ne kadar belirleyebiliyorsunuz? Ne kadar şirket öncelikleri mevcut?
5) Özel sağlık sigortası satmak istediğiniz bireylere hangi kanallar üzerinden ulaşıyorsunuz (Telefon, yüz yüze vs.)?
6) Özel sağlık sigortası satmak için iletişim kurduğunuz insanlarla konuşurken standart bir satış stratejiniz söz konusu mu?
7) İnsanların özel sağlık sigortası alma nedenleri sizce neler?
    a. İnsanların özel sağlık sigortası almama nedenleri sizce neler?
    b. Özel sağlık sigortası ürününü anlattığınız kişiler sıklıkla size ne tür karşı savlar öne sürüyorlar? Bu savlara nasıl yanıt veriyorsunuz?
8) Size göre Türkiye sağlık sistemindeki temel problemler/eksiklikler nelerdir? Bu bağlamda özel sağlık sigortasının ne gibi bir işlevi var?
9) Türkiye'deki sağlık sistemini göz önüne alacak olursak özel sağlık sigortası bu sistemin sunamadığı ne sunmaktadır?

10) Sizce tamamlayıcı sağlık sigortası ve standart özel sağlık sigortasının işlevi hangi açılardan benzer? Hangi açılardan farklı? Size danışan birine anlatırken bu iki ürünü birbirinden nasıl ayrıştırırsınız?
11) Tamamlayıcı sağlık sigortası ve standart özel sağlık sigortasını farklı özellikteki kişilere mi anlatırsınız? Yoksa her sağlık sigortası almayı düşünen kişiye her ikisini de anlatır mısınız? Neden?
12) Türkiye'de özel sağlık sigortası sektörü diğer ülkelerde olduğu gibi belirli yasal düzenlemelere tabii. Bu düzenlemeler içinde özel sağlık sigortası sisteminde aksaklıklara neden olan faktörler söz konusu mu sizce? Ya da bu düzenlemelerin herhangi bir eksikliği var mıdır?
    a. Sizce özel sağlık sigortası sektörünün iyileştirilmesi için ne tarz düzenlemeler getirilebilir?
13) İdeal bir sağlık sisteminde size göre özel sağlık sigortasının nasıl bir işlevi olmalı? Özel sağlık sigortası temelli bir sistem mi olmalı? Özel sağlık sigortası tamamlayıcı nitelikte mi olmalı? Neden?

APPENDIX C

CONSENT FORM

Supporting institution: Boğaziçi University

Title of the research: Selling Voluntary Health Insurance in a Publicly-Funded System: A Study with Insurance Agents in Turkey

Project Executive: Assist. ProfessorVolkan Yılmaz

E-mail address: xxx@boun.edu.tr

Phone: +90 212 XXX XX XX

Researcher's name: Oğuzhan Hışıl

E-mail address: xxx@gmail.com

Phone: +90 542 XXX XX XX

Dear respondent,

A scientific research project under the title of "Selling Voluntary Health Insurance in a Publicly-Funded System: A Study with Insurance Agents in Turkey" is being carried out by Prof. Dr. Volkan Yılmaz, a faculty member of Boğaziçi University Social Policy Program, and Oğuzhan Hışıl, a graduate student in Social Policy. Within the scope of the research, based on the worldwide literature on the rising private health insurance uptakes, it will be tried to understand that how insurance agents construct/determine their sales discourses. In other words, this research will focus on what information are based on sales strategies and how these strategies are experienced during sales. For this purpose, open-ended questions will be asked to employees so that they can share their relations with both customers and companies and their own

experiences in this network. In-depth interviews will be conducted with 8 policy sellers, including you, who work in a different or the same company.

This research is conducted for a scientific purpose and the confidentiality of participant information is taken as basis. Participation in the research is completely optional. If you consent to participate in this study, you have the right to withdraw your consent at any stage of the study without giving any reason. The interview will take approximately forty-five minutes. The questions were prepared in such a way that no psychological or legal risks were created for the participants. Maximum care will be taken to ensure that you do not experience any discomfort during the interview.

Audio recording is needed to accurately reflect the experiences and opinions you convey. Names and personal information will be changed, anonymized and encoded in order to protect privacy while voice recordings are being transcribed. Sound recording files and transcribed versions of sound recordings will be destroyed after the work is completed.

Please ask if you have any questions about the study before signing this form. If you want to get additional information about the research project later, if you have any questions, pleasee contact with project researcher Oğuzhan Hışıl (e-mail: oguzhanhisil@gmail.com; phone: +90 542 353 67 69) and/or project manager Volkan Yılmaz (e-mail: vyilmaz @ boun.edu.tr; phone: +90 212 359 75 63). For your questions and complaints about the relevant project, please contact Boğaziçi University The Ethics Committee for Master and PhD Theses in Social Sciences and Humanities.

I understood what was told to me and what was written above. I have/do not want to receive a sample of this form (in this case the researcher keeps this copy).

Participant's Name-Surname:.....

Signature:.....

Date (day / month / year):...../...../.....

Researcher's Name-Surname:.....

Signature:.....

Date (day / month / year):...../...../.....

APPENDIX D

CONSENT FORM (TURKISH)

Araştırmayı destekleyen kurum: Boğaziçi Üniversitesi

Araştırmanın adı: Kamu Tarafından Finanse Edilen Bir Sağlık Sisteminde Özel Sağlık Sigortası Poliçe Satıcılarının Söylemlerinin İncelenmesi: Türkiye Örneği

Proje Yürütücüsü: Dr. Öğretim Üyesi Volkan Yılmaz

E-mail adresi: xxx@boun.edu.tr

Telefonu: +90 212 XXX XX XX

Araştırmacının adı: Oğuzhan Hışıl

E-mail adresi: xxx@gmail.com

Telefonu: +90 542 XXX XX XX

Sayın katılımcı,

Boğaziçi Üniversitesi Sosyal Politika Anabilim Dalı öğretim üyesi Dr. Öğretim Üyesi Volkan Yılmaz ve Sosyal Politika Yüksek Lisans öğrencisi Oğuzhan Hışıl tarafından "Kamu Tarafından Finanse Edilen Bir Sistemde Özel Sağlık Sigortasının Satımı: Sigorta Acenteleri Üzerine Bir Çalışma" adı altında bilimsel bir araştırma projesi yürütülmektedir. Araştırma kapsamında literatürdeki dünya genelinde özel sağlık sigortası üyeliğindeki artışa yönelik araştırmalar temel alınarak, katılımcıların Türkiye sağlık sistemi kontekstinde satış söylemlerini nasıl kurguladıkları/belirledikleri anlaşılmaya çalışılacaktır. Yani bu araştırma satış stratejilerinin hangi bilgileri esas alarak oluşturulduğu, bu stratejilerin satış esnasında nasıl deneyimlendiği üzerine yoğunlaşacaktır. Bu amaçla çalışanlara hem müşterileriyle hem şirketleriyle olan

ilişkilerini, bu ilişki ağında kendi deneyimlerini aktarabilmeleri adına açık uçlu sorular yöneltilecektir. Saha çalışması siz dahil olmak üzere farklı veya aynı şirkette görev alan 8 poliçe satıcısı ile derinlemesine mülakat yapılacaktır.

Bu araştırma bilimsel bir amaçla yapılmaktadır ve katılımcı bilgilerinin gizliliği esas alınmaktadır. Araştırmaya katılmak tamamen isteğe bağlıdır. Bu çalışmaya katılıma onay verdiğiniz takdirde çalışmanın herhangi bir aşamasında herhangi bir sebep göstermeden onayınızı çekme hakkına sahipsinizdir. Görüşme yaklaşık kırk beş dakika sürecektir. Sorular katılımcılara yönelik psikolojik ya da hukuki herhangi bir risk oluşturulmamasına özen gösterilecek biçimde hazırlanmıştır. Mülakat esnasında da herhangi bir rahatsızlık yaşamamanız için azami özen gösterilecektir.

Aktardığınız deneyimlerin ve görüşlerin doğru yansıtılması için ses kaydına ihtiyaç duyulmaktadır. Ses kayıtları yazıya aktarılırken gizliliğin korunması açısından isimler ve kişisel bilgiler değiştirilecek ve anonim hale getirilerek kodlanacaktır. Ses kayıt dosyaları ve ses kayıtlarının yazıya dökülmüş halleri çalışma tamamlandıktan sonra imha edilecektir.

Bu formu imzalamadan önce, çalışmayla ilgili sorularınız varsa lütfen sorunuz. Daha sonra araştırma projesi hakkında ek bilgi almak istediğiniz takdirde sorunuz olursa, proje araştırmacısı Oğuzhan Hışıl (e-mail: oguzhanhisil@gmail.com; telefon: +90 542 353 67 69) ve/veya proje yürütücüsü Volkan Yılmaz (e-mail: vyilmaz@boun.edu.tr; telefon: +90 212 359 75 63) ile temasa geçiniz. İlgili proje hakkında sorularınız ve şikayetleriniz için Boğaziçi Üniversitesi Sosyal ve Beşerî Bilimler Yüksek Lisans ve Doktora Tezleri Etik İnceleme Komisyonu ile iletişime geçiniz.

Bana anlatılanları ve yukarıda yazılanları anladım. Bu formun bir örneğini aldım / almak istemiyorum (bu durumda araştırmacı bu kopyayı saklar).

Katılımcının Adı-Soyadı:.....

İmzası:.....

Tarih (gün/ay/yıl):...../...../.....

Araştırmacının Adı-Soyadı:.....

İmzası:.....

Tarih (gün/ay/yıl):...../...../.....

APPENDIX E

ETHICS COMMITTEE APPROVAL FORM

Evrak Tarih ve Sayısı: 28/09/2020-158

T.C.
BOĞAZİÇİ ÜNİVERSİTESİ
SOSYAL VE BEŞERİ BİLİMLER YÜKSEK LİSANS VE DOKTORA TEZLERİ ETİK İNCELEME KOMİSYONU
TOPLANTI TUTANAĞI

Toplantı Sayısı	:	7
Toplantı Tarihi	:	28/09/2020
Toplantı Saati	:	11:00
Toplantı Yeri	:	Zoom Sanal Toplantı
Bulunanlar	:	Prof. Dr. Feyza Çorapçı, Dr. Öğr. Üyesi Yasemin Sohtorik İlkmen, Prof. Dr. Özlem Hesapçı Karaca, Prof. Dr. Ebru Kaya, Prof. Dr. Fatma Nevra Seggie
Bulunmayanlar	:	

Oğuzhan Hışıl
Sosyal Politika
Sayın Araştırmacı,

Daha önce onay almış olan SBB-EAK 2020/08 sayılı eski başlığı "Kamu Tarafından Finanse Edilen Bir Sağlık Sisteminde Özel Sağlık Sigortası ve Poliçe Satıcılarının Söylemlerinin İncelenmesi: Türkiye Örneği" olan projeniz ile ilgili 26 Eylül 2020 tarihinde yapmış olduğunuz proje başlık değiştirme başvurunuz 28 Eylül 2020 tarihli toplantımızda incelenmiş olup, projenizin başlığının "Kamu Tarafından
Finanse Edilen Bir Sistemde Özel Sağlık Sigortasının Satımı: Sigorta Acenteleri Üzerine Bir Çalışma" olarak değiştirilmesi komisyonumuz tarafından uygun bulunmuştur.

Bu karar tüm üyelerin toplantıya çevrimiçi olarak katılımı ve oybirliği ile alınmıştır. COVID-19 önlemleri kapsamında kurul üyelerinden
ıslak imza alınamadığı için bu onam mektubu üyeve raportör olarak Fatma Nevra Seggie tarafından bütün üyeler adına e-imzalanmıştır.

Prof. Dr. Fatma Nevra SEGGIE
ÜYE

e-imzalıdır
Prof. Dr.Fatma Nevra SEGGIE
ÜYE

SOBETİK 7 28/09/2020

Bu belge 5070 sayılı Elektronik İmza Kanununun 5. Maddesi gereğince güvenli elektronik imza ile imzalanmıştır.

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