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Transforming the Gendered Regime Through Reproductive Politics: Neoliberal Health Restructuring, The Debt Economy and Reproductive Rights in Turkey

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Abstract

The “Health Transformation Program,” started by the AKP (Justice and Development Party) in 2003 in Turkey, is part of the global neoliberal “Health Sector Reforms-HSRs” which have been undertaken since the late 1980s and early 1990s with the support of World Bank advisers and reports, in various ‘developing’ countries such as Brazil, Mexico, South Korea, Taiwan, always with the rationale of a “health crisis” (increasing costs of health care), a need to prevent public corruption and bring “efficiency.” Similar to these other contexts, the Turkish health reform or health restructuring as we call it, comprised changes to finance mechanisms and provision of care and introduced a premium-based compulsory health coverage system. Alongside the neoliberal policies, there has also been a rise in the New Right under the AKP regime, which had at its center anti-women discourses, policies and implementations, including a pronatalist discourse and implementations and statements equating abortion with murder. To contribute to the existing feminist literature that analyzes the intricate links between capitalism, neoliberalism and gender, especially on connecting the latest stage of neoliberalism—the debt economy—to reproductive rights, we designed a multisite feminist research to investigate the effects of neoliberal health-structuring on reproductive rights in Turkey, France and the U.S. Our theoretical groundings are in transnational feminist theory and writings on the state of neoliberalism and the debt economy, especially those of Lazaratto and Berardi. In this paper, we discuss our findings in Turkey, especially the focus-group interviews with healthcare providers.
working in family health centers, in order to reveal how the gender regime in Turkey is being transformed via reproductive and body politics. Analyzing our existent data on Turkey in light of the writings on the debt economy, we observed the neoliberal mechanisms of the dismantling of the public/privatization and the creation of individual debt and quantification of care (as related to mathematization of life and language). We witnessed how these neoliberal mechanisms interact with the conservative discourse leading to the erosion of women’s rights to access contraceptive and abortion care in Turkey and a transformation of the gender regime through the alteration of its reproductive politics.

Introduction

The “Health Transformation Program,” started by the AKP (Justice and Development Party) in 2003 in Turkey is part of a global neoliberal trend that is referred to as "Health Sector Reforms-HSRs" in World Bank terminology, or as "health reform epideemics" by Klein. These reforms have been undertaken since the late 1980s and early 1990s by various ‘developing’ countries such as Brazil, Mexico, South Korea or Taiwan, but also in the U.S., and always with the rationale of a “health crisis” (increasing costs of health care), as a need to prevent public corruption and to bring “efficiency.”

The current health reform in Turkey is a continuation of the neoliberal economic and health policies of the late 1980s. In 1987, the Health Services Law was proposed to decentralize public hospitals and enable new management and personnel policies. In 1989, preliminary work for a national health policy was conducted, and in 1990 several projects and conferences – organized by the Turkish ministry of health and supported by the

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World Bank – proposed reforms to restructure the health sector. Yet, due to the unexpected death of the Turkish President Ozal and the consequent change of political climate and bureaucrats, and the lack of support from labor unions, the Turkish Medical Association, or academics, these reforms were dropped till the AKP government picked up this agenda again in 2002, under the name “Health Transformation Programme”. Similarly to other countries, this latest reform in Turkey was also begun in the context of the World Bank aid (Conditional Cash Transfer Program to Turkey in the early 2000s to support social policies) and took shape within the ministry of health through reports prepared by public health academics of Harvard and Johns Hopkins, in consultation with World Bank advisers.

With its three main components of change in finance mechanisms, service provision, and the implementation of compulsory health insurance, the Turkish health reform shares many of the characteristics of the neoliberal global health reforms such as financial reform, managerial reform, changes in service provision (e.g. privatizations, introduction of user fees), decentralization, and quantification of services over quality of care in the name of ‘cost reduction’, ‘efficiency,’ etc. In terms of changes in financing and provision of care, primary and secondary care were reorganized. A purchaser-provider split was introduced whereby the single payer organization SGK (Social Insurance Organization) contracted with public and private providers that competed to provide the ‘highest quality services at lower cost.’

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Health facilities, owned and operated by insurance funds and municipalities, were transferred to the Ministry of Health in 2005, introducing a strict separation of insurance organizations from providers. This is a break from the previous arrangement under which the SGK both financed care and managed its own hospitals. Semin and Aras\(^4\) note that this trend in reducing the state’s role to the regulation of health services, instead of financing and providing care, follows from the “free market policies” Turkey has followed since the 1980s, which include the recognition of many global regulations affecting medicine and related industries such as the TRIP (Trade related aspects of Intellectual Property Rights) agreement and the movement towards customs unity with the EU. After the 1980s, the government also provided important incentives for investment in private health care, financing expensive equipment and private hospitals. The number of private hospitals more than doubled between 2002 and 2015\(^5\).

Changes in healthcare provision include the replacement of the “community health center” system by the “family physicians system” in primary care. Family physicians were intended to be the ‘gatekeepers’ of the system; they would provide preventative care and refer patients to other providers for specialized care when needed\(^6\). Different from the previous community health centers system, the family physician system brought on a form of semi-privatized care, which added to the ongoing privatization of care through the introduction of user-fees in public care, the increase in the number of private hospitals and the increase in co-payments of hospitals. The family physicians work

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as contract workers who contract midwives and nurses for a period of 2 years, with their wages based on capitation set by the socioeconomic development of their region. The salaries of physicians, midwives and nurses are subject to performance criteria and can be cut by up to 20% when they fail to reach their targets. Instead of serving a geographic area (as previously done), Family Health Centers (FHCs) serve the population who register under them. Physicians compete with one another to keep their population and to keep patients that have less chronic problems. The last major change in the Turkish health system is the compulsory health insurance scheme. In January 2012 the GHIS (General Health Insurance Scheme), a premium based system, was made compulsory for the entire population.

Alongside these neoliberal policies, there has also been a rise of the New Right under the AKP regime. Liberalism had historically allied itself with conservatism in order to protect private property and the increasing capitalist accumulation from the consequences of a possible spreading of the 1789, 1830 and 1848 revolutions. This alliance became stronger and more explicit during the transition to neoliberalism, with the utilization of conservative values such as religion and family during Thatcher, Reagan and Bush Sr. periods. This renewed alliance has been named neo-conservatism or the rise of the New Right. As in these past administrations, and in the current U.S. administration (of Donald Trump), in the AKP regime of Turkey, this alliance between neoliberalism and social conservatism has at its center, anti-women and at times misogynist discourses, policies

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7 For coverage details, please see [http://www.sgk.gen.tr/genel/gss-zorunlu-mu.html](http://www.sgk.gen.tr/genel/gss-zorunlu-mu.html)

and implementations that reposition women in familial roles, overturning decades of gain by feminist movements in Turkey for the recognition of women as individuals and citizens in their own right.

Examples of the anti-women implementations in Turkey are: the abolishment and replacement of the “Ministry of State Responsible for Women and Family” by the “Ministry of Family and Social Policy” (June 8, 2011), highlighting family as “the pillar of society, national unity and social welfare” and relegating many social care services to women⁹; the introduction of “flexible” employment packages for women¹⁰, thus privileging maternity leave and prenatal follow-ups over contraception and abortion; and the dissemination of anti-scientific information on women’s bodies to women by clerics in neighborhood Koran lessons (e.g. that IVF and IUDs’ are sinful, that they are impure during menstruation, etc.)¹¹ In addition to these, the AKP government has been promoting a pro-natalist policy, mainly through discursive strategies, and through certain policy propositions, framed in the moral panic context of an ageing and declining population (that are not true), and culminating in the moral and national duty of women to increase the population in order to uphold economic growth. During the International Women’s Day celebrations of March 8th, 2008, then-Prime Minister Erdogan announced his government’s plans to introduce financial incentives for births, which in 2009 and afterwards, quickly turned into a formulation of three children per family

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¹¹ This last point was observed by the second author in many of the trainings she provided in the KSEP Program (Women’s Health Education Program) – where the women participants reported to her and her co-trainers such statements of religious clerics during Koran lessons they attended.
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(i.e. per women). These were repeated by the prime minister, ministers and mayors12 and amplified by the then semi-free press13. Acar and Altunok14 mention that the initial sign of this shift in policy – from the anti-natalist stance upheld by governments in Turkey since the 1960s, to a pro-natalist one – was in 2003. It was in the government’s attempt to draft anew the Law on the Rights of the Disabled, which would bring restrictions to abortions done after 10 weeks, allowed with the medical reason of fetal disability. Due to objections by women’s organizations, medical associations, and some of the media, the proposed article was removed from the draft. Yet, Prime Minister Erdogan made a personal statement on abortion in May 2012, during the closing session of the Parliamantarians' Conference of the UN Population Fund (UNFPA) that was held in Istanbul, saying that abortion was mass murder, later adding that caesarian sections were murders as well, and declaring both to be “secret plots designed to stall Turkey’s economic growth and a conspiracy to wipe the Turkish nation from the world stage,”15. This was followed by the ever-more violent statement of the then Minister of Health, Recep Akdag, declaring that women should give birth and no have abortions, even in the cases of rape. The pro-natalist policy was also supported by the amendment to the “Regulation Concerning Treatment Centers for Assisted Procreation” in 2010, which permitted the use of assisted reproductive technologies, though only for heterosexual and married couples, and only in cases of consent from both parties, with the process to be terminated at the death (of the husband) or in the case of

15 Hurriyet Daily News, 26 May 2012
divorce. It did not permit third party reproduction or egg, sperm or embryo donations (for the “protection of lineage” – meaning paternal descent – deemed important for inheritance)\textsuperscript{16}. By various incentives the government said they would introduce awards for mothers having three and more children\textsuperscript{17}. As we will also show with our findings in this paper, although there has not been an official change in the population policy, nor any change in the abortion law, this unofficial pronatalist policy has been successful in creating problems to access abortion and birth control through discourse, pressure on medical providers and neoliberal measures. The decrease in abortions in public hospitals throughout Turkey has been documented in the recent survey of state hospitals and teaching state hospitals by Kadir Has University\textsuperscript{18} (2016), while others detected a decrease in contraceptive methods, especially in IUD (Intra-Uterine Device)\textsuperscript{19}, and the beginning of a potential rise in birth rates\textsuperscript{20}.

Our Research-Advocacy Project
Feminist scholars have analyzed the intricate link between capitalism and gender\textsuperscript{21} and between capitalism, neoliber-

\textsuperscript{20} TNSA, ibid.
alism and biopolitics. Others clearly showed the evidence of globalized neoliberal politics’ disastrous effects on reproductive health. Despite these, we believe that there is more feminist work to be done in linking political economy – especially the current stage of neoliberalism, the debt economy – to reproductive rights from a transnational feminist perspective. This is also the case for research on Turkey. Previous research on the effects of the health reform on reproductive health has focused either on female health care providers (midwives and nurses) or on the women receiving care, but not on both. There are two main


studies on the effects of social conservative discourses and pressure on abortion care. Yet, none of these situate these processes within the neoliberal globalization and thus lack the political economic lens and transnational analysis.

In order to fill these gaps and contribute to feminist literature on neoliberal globalization and sexual/reproductive rights, we designed a multisite feminist research/advocacy project to analyze the effects of neoliberal health restructuring on sexual/reproductive rights in Turkey, France and the United States. We chose these three contexts for the differences in their healthcare systems, with the U.S. having a fully neoliberal privatized health care, France having a social healthcare system with an acceleration of neoliberal infringements since the Sarkozy mandate, and Turkey providing a case in the middle with a social health system which is being rapidly transformed into a neoliberal system. Through interviews with women and health providers, and the analysis of policy documents and media coverage, our aim is to make visible the link between neoliberal health policies and reproductive rights with their (direct and indirect) intermediary mechanisms, which include the use of neocconservative discourse.

In this paper we discuss our findings on family health-center workers from Turkey to reveal how the gender regime in Turkey is being transformed via reproductive and body politics. Our theoretical groundings are in transnational feminist theory.


and writings on the state of neoliberalism and the debt economy, especially those of Lazaratto\(^\text{27}\) and Berardi\(^\text{28}\).

Theoretical background
We utilize transnational feminist theory for its emphasis on neoliberal globalization. As opposed to global feminism, transnational feminism is engaged with the processes of political economy in general and neoliberal globalization in particular\(^\text{29}\), thus highlighting the racialized gendered nature of neoliberal globalization and calling for feminist theorizing, critique, and activism around antiglobalization. Used together with writings on the debt economy, we hope to highlight how reproductive rights in different contexts are impacted by similar neoliberal mechanisms, with variations depending on medical, religious and ethnic/racial factors.

We utilize the writings on the debt economy for their revelation of the current state of neoliberalism and its workings through the public-private lives and bodies of women. Maurizio Lazzarato\(^\text{30}\) calls the new phase of neoliberalism (from 2000s onwards) “the debt economy”, which he argues is a more appropriate term than finance, financialized economy or financial capitalism to describe the regime of power that is currently running the global scene. In the debt economy, finance dominates every sector of the economy (and society) – from housing, edu-


\(^{30}\) Lazarato, Op.cit
cation and health to public services\textsuperscript{31} – and is integrated into all areas of production. “Homo economicus” or “entrepreneur of the self” as described by Foucault has now turned into “indebted human” where all individuals, public and private agencies and entire governments are indebted and run through a credit-debt relation\textsuperscript{32}.

The debt economy is based on multiple abstractions and deterritorializations. Money, labor and the capitalist class itself are abstracted and deterritorialized. Without a standard, a referent and regulation\textsuperscript{33}, in the debt economy money creates money (through ratings, speculations, investments) “without the generative intervention of physical matter and muscular work.” Thus money is abstracted from bodily labor, the value of labor, etc.\textsuperscript{34} (Berardi, 2012, p. 19). In analyzing the debt economy, Berardi emphasizes the “mathematization of life and language,” where neoliberal ideology, pretending to be a liberating force that “emancipates capital from state regulation, but in fact submits production and social life to the most ferocious regulation, the mathematization of language” (p. 31). Social life is reduced to mathematical implications of financial algorithms.

Through privatizations and the determination (and imposition) by banks, rating agencies or investment agencies’ determination of interest rates, and the “appropriate rates” of for example unemployment wages, pensions, public services, farmers’ “optimal” production or public debt rates (of governments, municipalities, etc), colossal sums of public money are transferred into private hands. Through these, the public sector (including

\begin{itemize}
\item[\textsuperscript{32}] Lazzarato, Op.cit
\item[\textsuperscript{33}] Berardi (2012) notes that Richard Nixon’s 1972 decision to break the Bretton Woods agreement to declare that the dollar’s value would not be determined by the gold standard marks the beginning of financialization of the economy.
\item[\textsuperscript{34}] Ibid, p. 19
\end{itemize}
the welfare state) is completely dismantled, privatized and public debt is created; “collective” or “social rights” are turned into social and individual debt, the role of the state is turned into a regulator of services, itself bound to credit and debt mechanisms. The subjectivity created in this system is personal- ized/individualized risk and responsibility where the individual and the population are expected “to take charge of everything business and the Welfare State have (through taking it out of state protection and leaving it to the market forces) “externalized” onto society, debt first of all” (p. 9). Individuals and populations are made to pay the costs of monetary crises, the saving of banks, and austerity measures.

Missing from Lazaratto, Berardi and others’ analyses of neoliberalism and the debt economy is the racialized gendered nature of neoliberalism. Neoliberalism is a gendered racialized project that affects women through multiple intersecting mechanisms of the dismantling of the welfare states, the implementation of austerity measures\(^{35}\), the promotion of micro-credit schemes that are actually impoverishing\(^ {36}\), the restructuring of health systems and sexual/reproductive health care\(^ {37}\), the re-

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structuring of labor into part-time/contract labor, the increased migration of women to the West and North (as maids, nannies, sex workers and now as refugees), and through the biotechnical commodification and devaluation of life and health in general, and of women’s bodies and reproduction in particular. The effect of the biotech industry on women has been studied by scholars such as Cooper and Walby and Cooper in terms of the connections between the biotech industry and neoliberalism, and regarding the debt economy and reproductive labor in commodification of egg markets. Others studied the commodification of pregnancy and motherhood through commercial surrogacy, in vitro fertilization, transnational adoption markets and maternal labor, and the increased capitalist medicalization of childbirth. We would like to contribute to this feminist literature, especially by linking neoliberalism to reproductive health, while bringing in the aspects of the debt economy and transnational feminist analysis of this link.

**Our methodology**

In order to see the effects of the debt economy on reproductive rights, especially through infringements on abortion and birth control services and rights in Turkey, we designed a study to collect data from seven different cities: Istanbul, Izmir, Antalya, Van, Eskişehir, Diyarbakır, and Gaziantep. We chose these cities to reflect the geographical regions and variations in these regions’ healthcare and reproductive healthcare access, as found in the TNSA: the Turkish Population and Health Survey.

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conducted every five years in Turkey. We also chose these cities for the existence of women’s organizations and medical associations that would help us conduct our research. Our aim was to conduct five focus groups in each city with women between the ages of 18–45 who receive gynecological services either from the public or the private sector, and five focus groups with physicians, nurses and nurse-midwives who work in « family health centers » (FHCs). We targeted the family health centers’ personnel since this was one of the main sites of the reform where we expected to see the impacts of the changes in finance mechanism, service provision and the dismantling and transformation of public care. Some of these personnel had served in the former « community health centers » and could provide us with a comparison of the two systems. In each city, we planned 100 surveys with health personnel who worked in reproductive care in the public sector at primary and secondary levels and 100 surveys with women from diverse neighborhoods.

As of now, we have data from four of the seven cities: Izmir, Diyarbakir, Van, and Gaziantep. In these cities, we completed a total of 313 surveys with women from the four cities, 103 surveys with health personnel in Diyarbakir and Antep, 14 focus groups with women (from all four cities with only one focus group in Van), and 8 focus groups and 3 individual interviews with FHC personnel in cities except Van. The health personnel focus groups represent 11 FHC’s and one Maternal-Child Health Center (ACSAP in Turkish).

The mean age of the women in focus groups was 35.5 and 32.6 in the surveys. For the health personnel, this was 36.6 for focus groups and 35.4 for surveys. In terms of marital status, 63.9% of women who completed surveys were married whereas there were slightly more single women in our focus groups (53.6%). The health personnel who participated in surveys and focus groups were mainly female health workers (77.7% for
surveys and 85.7% for focus groups), with the majority being nurses or midwives 75.7% of health workers in surveys and 81.8% of health workers in focus groups). Thus, we can say that the results reflect more the viewpoint of the feminine labor-force on healthcare restructuring. In this paper, we mostly utilized focus groups with health providers; as to their experience of, and views on, the effects of the health reform on their professional lives and on reproductive care.

Findings

Analyzing our existent data on Turkey in the light of the writings on the debt economy, we observed the neoliberal mechanisms of the dismantling of the public/privatization and the creation of individual debt and quantification of care (as related to mathematization of life and language). We witnessed how these neoliberal mechanisms interacted with the conservative discourse (that created a confusion on abortion access and put pressure on medical providers not to provide abortion or birth control) to lead to an erosion of women’s rights to access contraceptive and abortion care in Turkey

Dismantling of the public sector, privatization of care and construction of public debt

Within the health “transformation” program, the health ministry itself is restructured – in order to withdraw from being a service provision and instead to adopt a more regulatory role – and decentralised, with more autonomy being given to local governments. This eased the privatization of care and the transfer of healthcare from public and state monitored to market mechanisms. This can be seen in social security agencies contracting private care, public hospitals being made into business

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ventures managed in the style of the private sector (with contracted experts and performance measures, etc.), contractual hiring of health providers, and in the family physician system which runs like a semi-private system. In the new family physician system, the public teamwork of “community health centers,” had been replaced by a physician-based system, where the physician is transformed from a public worker into an “entrepreneur,” who contracts the personnel, pays rent and any material costs that arise. Nurses and midwives in turn became contractual workers, whose professional titles have been changed from “nurse”/“midwife” to “family health worker,” losing both professional status and the job security granted previously by the public worker status.

In our findings, we observed how some physicians opposed this new system, which they saw as “corporatization/commodification” of healthcare. They were frustrated and confused by this new unclear status, since they functioned like a private enterprise when it came to keeping their office, etc, but were also held accountable to the ministry in providing primary care:

*The community health centers had to be updated (a short pause). This is the way of the world. There will be change. If you try to run the community health centers as you did in the 1970s, it won’t work. They needed to be updated and adapted to 2016s and 2017s and it wasn’t done. That wonderful system is gone now and in its place we have a commercial- (Eylem: agencies). Like the commercial agencies, but we are not that. In-between. We pay the electricity, water, internet, heating, cooling, all..* 

*Hired five personnel. If something happens to this place, we

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pay for it. From our own thing. We get a tax number, and we spend 70% of our time with this nonsense (Another health worker in the room: management) work.

Mehmet (male), age 52, Physician, Antep A Type FHC

This kind of system is IMPOSSIBLE. I can’t get natural gas to the building. I pay the municipality but the municipality sees me like a pharmacy, like a for-profit agency. You try to tell that you are providing primary level of care and are not a for-profit agency, that we are tied to public health directory, they don’t understand. The system sees you as a contracted worker. (Eylem: as private sector) Yes, makes you into private sector, but when the time comes, the state changes your position. You are private on one hand, public on the other hand. For example, in taking these tests for hidden blood in the stool, we became public.

Ayse (female), Physician, age 39, Antep D Type FHC

The family physician system also broke down the cooperative teamwork that existed between health workers in the previous community health centers model and exacerbated the inequalities between physicians and nurses/midwives by turning their relationship into a business relationship (employer/employee).

FHC system has good and bad aspects. The good part is that we are more organized in work now, we are more aware of what we are doing. I mean we know all of our patients. Uhm, the bad part is that you are directly related to the doctor (Eylem: as an employer?) yes. Like you constantly feel the pressure of the contract being annuled.

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44 In the new system, the FHCs were organized into A, B, C, and D categories, where only the centers in A and B categories are required to have a specific room reserved for family planning and prenatal follow-ups.
Su (female), age 36, midwife, A Type FHC, Diyarbakir

There are problems both in terms of money we receive, and status. and it’s like a boss-employee relationship. Intentionally or unintentionally. Even though they (doctors) don’t pay you, we are in that position.

Gul (female), age 35, midwife, A Type FHC, Antep

In the new system, performance measures were introduced for both hospital and family health centers work. In the family health centers, physicians, nurses and midwives are now subject to performance measures in areas such as rate of referrals, child vaccinations, and prenatal and infant follow-ups, the effects of which – on reproductive care – will be described in the next section, but it is important to mention it here as well, for these are important indicators of the dismantling of public care and the introduction of market measures of performance and competition to healthcare.

The health transformation program also included explicit terminology of increasing “user satisfaction” in healthcare, whereby the patients were transformed into “customers” who could “choose” their primary care doctors (and private healthcare as well, if they had money). We heard from the health providers that this new customer role was exploited by the patients into pushing physicians to write them prescriptions, urging nurses to come to their homes for vaccinations, etc. Possibly being aware of performance measures and the money paid per person in the care of the physician, some individuals felt entitled – not as a health right, but as a customer – to demand such services.

"the health personnel is devalued. You go to the man’s house, he says “come do your vaccination here. Aren’t you our
(family) nurse? YOU have to come, you have to do it.” (Eylem: so, he perceives the family physician and family nurse differently). Exactly. Says you need to come to me.

Su (female), age 29, midwife, A Type FHC, Diyarbakir

(talking about performance measures) There is nothing for the patient. Why punish me? Patient has no responsibility. If s/he doesn’t come, s/he doesn’t come. S/he can even do this as punishment. Knowing that the doctor receives 1 Tl extra for each patient, s/he says “you are sitting here with my money.”

Leyla (female), age 26, Midwife, A Type FHC, Diyarbakir

With the manipulations of the politicians, the pregnant woman profile has changed a lot. A patient comes and says you are here to write my prescriptions, you receive 12-13 billion Tl’s. They are given these kind of nonsense information. Who gets that kind of money I don’t know.

Mehmet (male), 52 years old, Physician, A Type FHC, Antep

This perception of the family health center as a prescription-writing place is also due to the failure of the reform to transform family health centers into a gateway system, from where the physicians were initially supposed to refer patients to all other specialized care. With that role being abandoned after three months of trial, and with the rest of the preventive care still there but with some being monitored by performance measures and some not, and with an ongoing polyclinic-like basic treatment, the exact role of the new FHCs is not clear to health workers and patients alike.

The last aspect of dismantling of the public healthcare we would like to discuss here, is the indebting of individuals to the system – health workers via performance measures and women who use the services via compulsory health insurance and the explicit and unseen costs of user fees.
They brought this system under the flashy name of “general health insurance,” bragging about it, yet people are unable to get their medicine. For example, the person has health care, goes to the public hospital, yet when s/he gets his/her prescription, needs to pay a lot of money. And sometimes they can’t pay that amount. That amount rests there (Eylem: it’s taken out of your pension) Sure sure, taken out of your pension but the money accumulates and because you owe to the pharmacy, you can’t get your drug.

Arin, age 40, nurse, ACSAP (Maternal-Child health Center), Diyarbakir

This nurse is referring to the changes brought by the health reform where user fees were introduced under the title of “co-payment”, and pharmacies designated as places where the payments for treatments and prescriptions (for public services) for all individuals, except pension holders, would be collected. In this new system, user fees were introduced for previously free public health care, with individuals now paying a user fee for secondary and tertiary care in state and university public hospitals and incurring a co-payment for prescriptions, including those received from primary care (e.g. family health centers). For pension holders, the cost of treatments in public care and prescriptions are withdrawn from their pensions, while for the workers (and dependents), the cost stays in the pharmacy only to reemerge at the next time of service at the pharmacy. Thus, the treatment cost is hidden.

In addition to introducing user fees, the premium-based system itself creates debt for individuals. The health transformation program promised to bring universal coverage through a premium-based compulsory health insurance scheme. According to this, all individuals (except children under 18, soldiers, in-
mates and those who are insured abroad), whose monthly income is above one-third of the minimum wage (a very low amount), have to pay a monthly premium in order to have health insurance coverage. The government pays for those individuals whose income falls below this level. In this kind of premium-based compulsory health insurance system, citizens who do part-time or seasonal work, those who are not the dependents of workers, and those who can’t pay their premiums are not only uncovered but are also indebted to the system. Those with low income who fail to take the income test to determine their premiums can be charged with the highest premiums that accumulate interest rate on the debt. Regarding women, only 31% in Turkey are in paid labor, with 50% of these working women who do not have social security, and 11% of women are not covered by any health insurance (TNSA, 2013). Thus, women are indebted to the system through the compulsory premium based system, costs of user fees, and out of pocket costs incurred due to the regular cuts to contraceptive supply in family health centers (as will be seen in the next section).

Mathemeticization and Quantification of healthcare

Lazzarato explains how evaluation is a technique used in the debt economy to govern the behavior of individuals, populations, agencies and governments. Financial power promises a thorough “public” evaluation, “to make all organizations transparent, to make visible and thus accessible (measurable) the relations and behavior of the actors in each institution, whether it is a corporation, unemployment insurance, medicine, or the university” (p. 138). However, the public evaluation is never actually public, since assessment is done by rating agencies or public agencies, who themselves are linked to the financial bloc through which payments or credits are received. The process is also undemocratic since “it destroys what is left of

45 Lazzarato, Op.cit
“co-determination” (the shared management in welfare institutions) as it emerged in the 20th century, with the New Deal” (p. 139). Lazzarato gives examples from the indebtedness of the trade union UNEDIC in France (Union Nationale Interprofessionelle pour l’emploi dans l’industrie et le commerce). To maintain good ratings “unions and employers must act in accordance with the demands of rating agencies rather than with those of the unemployed (that they serve), since interest is tied to the ratings” (p.16). Another example comes from farming. He explains how, in CAP (Common Agricultural Policy) in Europe, through an electronic chip implanted in each animal, animals and farmers are entered into computer models and programs which contain options and scenarios decided by the domestic and European authorities and creditor agencies as to when and where to graze the animals, number of animals per acre, etc. “Everything must be reported and backed up with proof (dates, number of animals, vaccinations, diseases)” (p. 141). This takes away individuals’ power to act, automatizes them and their labor, and standardizes the whole procedure. Berardi\textsuperscript{46} discusses in even more depth the effects of this mathematization of language, discourse and life, proposing poetry along with insolvency as ways to free language and life from algorithms.

We observed the quantification and mathematization of health and reproductive health, through performance measures and increased paper and computer work, which had direct consequences on women’s rights to contraceptive care. Despite the aims of the reform, to bring “efficiency”, health providers in our research mentioned an increased workload and lack of efficiency. In our surveys 92.2% of health providers indicated an increase in patients since the health reform, with 86.4% mentioning an increase in workload as well. The increase in workload

\textsuperscript{46} Berardi, Op.cit
Ayse Dayi & Eylem Karakaya

was mainly due to requirements of the performance measures and the newly computerized system, which did not work efficiently at all.

Ayse: Sometimes I think that they make us do too many drudgery... for example, the monthly work, we print out the monthly work and transfer it from the computer into paper work, then you scan and enter it back into the computer, correct it within the EBES system, send it... Remove the monthly work. If you already have a system, why is it this way? Why do you waste so much paper?..if the system goes down, everything is affected. You can’t send something for hours. Fatma: yes, this is extra work for us

Ayse, age 37, Midwife, A Type FHC, Diyarbakır
Fatma, age 29, Nurse, A type FHC, Diyarbakır

The reform has been good for the people. For example, (previously) no one was calling patients this much for the vaccinations, for prenatal follow-ups. Now, after the performance system came, to complete the performance to 100%, they (nurses and midwives) call the people. This is a good thing but our workload increased.

Male health personnel, A Type FHC, Diyarbakır

As the workload increases, as one does polyclinic, and needs to follow the women aged 15-49 (meaning prenatal follow-ups of women in reproductive age range) and checks on obesity, you can’t catch up. If you do one, the other is definitely left out.

Malin, age 42, Physician, B Type FHC, Izmir

Performance system itself was not working efficiently either and created frustrations in healthcare workers due to increased workload (calling patients for vaccinations and prenatal follow-ups, etc.) and penalizations for cases out of their control. Nurses and midwives also mentioned how they do the majority
of the labor in these areas and face cuts to their salary and threats of losing their contract. The system created an incentive for fraud to avoid penalization:

_The system of FHC is in fact what should be brought on. And it did exist before. But the new system includes punitive measures. If you don’t do it, I will punish you like this.. If you miss the vaccination, you lose such and such points, I deduct it from your salary.. (Eylem: what if the woman doesn’t come?) You have to track her. In the previous system of health care centers, all had to follow vaccinations in their own region. What happened with this system of punishment? There are pen vaccinations, or clavier vaccinations, seem like you have done them. Not to be punished. I don’t think there is anyone who doesn’t do it._

Arin (female), age 40, Nurse, Mother-Child Center, Diyarbakir

Thus, even the preventive care and those “evaluated by performance measures” were not working as efficiently as promised. In their research with the providers in family health centers and community health centers, Ocek et al.\(^ {47} \) also found that even within the services subject to performance criteria, due to the lack of home visits, there were now serious problems in identifying the pregnant women and infants among individuals who did not register with them. They added that due to extreme workload, performance measures, lack of knowledge and skills, lack of coordination between physicians and nurses/midwives and delays in supplies of medicines and immunizations, there were also problems with quality of the prenatal care and infants provided for the registered women. As we did, they also found

the instances of false reporting of vaccinations. Thus, the ratio of pregnant women and infants not covered by this new system, as well as problems in the quality of monitoring, reveal a quantification of care which does not guarantee quality of care or even “efficiency.” Even the World Bank report “admitted that the performance-based contracting scheme in Turkey started out mostly as a ‘pay for quantity’ approach and does not incentivise the clinical process dimension in quality of care”\textsuperscript{48}.

In terms of the effects of this quantification of care on abortion and contraceptive care, some scholars previously detected a decrease in FHCs of IUD (Intra-uterine device) provision\textsuperscript{49} and family counseling\textsuperscript{50} as a result of increased workload and the exclusion of these services from performance measures. In our study, we also witnessed the decrease in IUD provision, due to increased workload, exclusion from performance measures and lack of adequate training and practice.

\textit{Last time I placed an IUD was last year. I don’t find it appropriate to do it here (Ayse: why?) Why? Pause, ihmm, there are patients waiting and there is the time for that patient. And when you don’t do something regularly (Ayse: you lose the hand-) lose the practise then. So I try to refer the patient where IUD is placed. Like maternal-child health centers.}

Zeynep (female), age 43, Midwife, B Type FHC, Izmir

\textit{If it was me, I would not have an IUD placed here. For example, I went and learned the IUD placement on a model. How can I do it on a woman, something I only performed on a model? I can neither place an IUD nor do smear. (Eylem: didn’t

\\textsuperscript{48} Ibid, p.11.
\textsuperscript{50} Ocek et al., op.cit
you practice before receiving the certificate?) we did not receive a certificate. A training for 20 minutes only.

Cicek (female), age 40, Nurse, A Type FHC, Diyarbakir

In addition to performance measures, workload, and lack of training, another bureaucratic mechanism that impeded women’s access and rights to contraception were periodic problems in the provision of contraceptive methods to FHC’s by the city health ministries. We heard about these periodic irregularities in supply in each city we interviewed. Some health providers attributed this to the incorrect way of calculating their needs (by the ministry) and not informing them of the supplies that had arrived. While reasons for these constant irregularities need to be studied further, the result is the violation of women’s right to free contraception (at the primary level) where women are left with the choices of paying out of pocket (being indebted), changing to another contraceptive method that might be available at the FHC, or carrying out an unwanted pregnancy.

Ayşe: We have it as long as the ministry (of health) sends it. When it’s finished, we wait till the next time they send it.

Fatma: last year, we had nothing for 4 months except for the injection.

Anonymous: most of the time the ministry buys it but it doesn’t come to us, waits there. The (city) municipality doesn’t inform us. There is a waiting. It’s a two way problem. Problem emanates 80-90% from the ministry.

Ayşe: of course, they send it to TSM (Community Health Centers) and they divide it by the number of FHC’s and physicians. Then call us to say come take it.

Eylem: Ok, so when there is nothing and the woman comes and asks for a method, what do you do?
Ayşe: They become pregnant. Cause you know the pill in the pharmacy is 18 Lira’s. They can’t buy it. They can buy as much as they can from the pharmacy, otherwise they become pregnant.

Fatma (female), age 29 Nurse, Ayse (female), age 37, Midwife
Anonymous (male), age 43, Physician, A type FHC, Diyarbakir

There is a big problem there. When you say “we can’t access birth control”, it’s as if we are committing a-, doing something wrong. But we can’t. We expressed this in a meeting, they said we will take a look at this in the system, whatever there is, there is, whatever you demanded. Then, our public health professor said (to them) your target population is known, numbers are known, analysis is clear, you do it like this and put a plus/minus amount and give it to the centers. Science requires this but they don’t ask me for my target population.

Ayse (female), age 39, Physician, D type FHC, Antep

Zeynep: for a time being, there was a problem accessing the pill at the end of the year. Then, there was a problem accessing condoms. Now there is no problem.

Habibe: As if it decreases near the end of the year.

Dorothy: but the patients who want a contraceptive can buy it from outside.

Zeynep: but there are those who can’t and get pregnant.

Habibe: there are those who get pregnant. There was no pill for a while for example, and we saw many women who got pregnant and gave birth to their whatever number child.

Zeynep (female), age 43, midwife,
Dorothy (female), age 28, midwife
Habibe (female), age 42, physician, B Type FHC, Izmir

Impeding access to abortion and contraception through conservative discourse and pressure
In focus groups, we asked healthcare providers and women about the access to abortion and birth control in their cities, especially since the health reform. A surprising find was that most of the women and the health providers were confused about the legal status of abortion, some thinking it was banned while others not being sure whether the legal period (of 10 weeks) had been decreased. To us, this showed that, the conservative discourse that started with Erdogan’s remarks in 2012 that “abortion is murder,” was successful in muddying the waters and creating a confusion in the minds of even health providers on the legal status of abortion and thus started creating a landscape of confusion and pressure without actually changing the law (which though prepares the groundwork for the legal change). We could not find out the actual change in access to abortion through our focus groups, since most of the providers and women did not know exactly about the access in the whole area (or in their neighborhoods). We got glimpses of cases where public hospitals denied abortion and women had to go to private hospitals. We witnessed the pressure health providers started to feel on talking about and providing abortion and birth control, and the newly brought scrutiny on the husband’s signature for abortion:
Actually there is a change (from the community center model to family health center model). Change in VIEW. How to say this.. Abortion is legal but there is an incentive not to provide it. You can’t talk about it, talk about this different point of view.
(Eylem: secret ban). For example, the person says “I don’t want to give birth, I want to use protection,” and you get the feeling that you are doing a wrong thing mentioning the methods (Eylem: there is a perception like that). Perception. As if you are doing wrong. We are talking about science, universal values. There is such a change here and it exists on abortion too. It is LEGAL, so I don’t still understand why the husband
comes. And you take the husband’s signature. (Eylem: you know that the health personnel does not need to see the husband, right?) Right.

Ayse (female), age 39, Physician, D Type FHC, Antep

Conclusion

In this paper, we discussed our data from healthcare providers in Turkey in the light of the writings on the debt economy, to analyze how neoliberal health restructuring affects women’s reproductive rights, especially rights to abortion and contraception. In line with Lazzarato’s and Berardi’s writings, the public system of health care is being dismantled and care is being quantified, with clear consequences for health providers and women. In line with the mechanisms described by Lazzarato, we saw how the public health system is dismantled through the restructuring of FHCs as semiprivate enterprises with unclear roles and boundaries, where physicians become “managers”/entrepreneurs, and their relationship to their coworkers turned into a business relationship. The relationship between the medical workers and patients, in turn, is transformed into a customer relationship. Performance measures highlight this market approach and the quantification of health and reproductive health care, which actually did not improve the quality of care, but instead led to fraud. In such a system, the debt that Lazzarato formulates, is incurred by both health providers (via losing their salaries) and by women who pay out of pocket for lacking contraceptive supplies and paying the hidden and explicit costs of use. The exclusion from performance measures of contraceptives, family planning counseling in family health centers, low performance points given to abortion in hospitals and the periodic irregularities in contraceptive supplies seem to be in line with the pronatalist policy of the AKP. We witnessed as well, how the discourse on abortion was successful in creating confusion in the minds of health providers and women and put pressure on
medical workers not to talk about or provide abortions and at times contraceptives. Thus, while abortion and contraception are still legal in Turkey, the landscape has been prepared for legal changes. The feminist movement in Turkey is aware and vigilant on this issue.

All of these represent a transformation of the gender regime through health restructuring and reproductive politics, where neoliberal financial and bureaucratic mechanisms, as reinforced with a conservative (and at times misogynist) discourse have a gendered impact, affecting both female health care providers and the women in reproductive age, causing an erosion in the rights of both. From here on, our aims are to deepen the analysis of the Turkish data (with analyses of women’s focus groups and surveys) and to continue to develop our analysis into a more transnational one, with added data added from France and U.S.

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