

The Southern European Model in Welfare Regime Types and a Comparison Among The Health Care Provisions in Italy and Turkey

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ABSTRACT

The category of the Southern European welfare regime type has basically composed of four countries; Italy, Spain, Portugal and Greece. Turkey's place has been discussed in the Gough's article (1996) because of its welfare regime, its division of social responsibilities among state, family and market analogous with the Southern European countries. In the field of health, as a part of social services, Italy and Turkey implemented a similar universal health reform package in 1978 and 2003, respectively, and the similarities and differences between these two countries should be analyzed within the framework of the Southern European welfare regime framework. In this point, the research question can be summarized as follows: How can these universal health systems of Turkey and Italy be compared in the framework of the Southern European welfare regime model? In this paper, we would like to focus on the Italian and the Turkish health care provisions under two dimensions: the provision of health care and the health care expenditure based upon OECD and WHO 2014 reports and with valuable contributions of the scope of related readings.

Key Words: *the Southern European welfare regime, universal health care reform, National Health System (SSN), Health Transformation Program (HTP).*

Refah Rejimi Tipolojilerinde Güney Avrupa Modeli ve İtalya ve Türkiye'de Sağlık Hizmetleri Sunumu Karşılaştırması

ÖZ

Güney Avrupa refah rejimi kategorisi temel olarak İtalya, İspanya, Portekiz ve Yunanistan olmak üzere dört ülkeden oluşmaktadır. Güney Avrupa ülkeleri ve Türkiye'nin bu ülkeler içindeki yeri benzer devlet, aile ve pazar arasındaki sosyal sorumluluk dağılımı nedeniyle Gough'un(1996) makalesinde tartışılmıştır. Sosyal hizmetlerin bir parçası olan sağlık alanında İtalya ve Türkiye, sırasıyla 1978 ve 2003'te benzer bir evrensel sağlık reformu paketi uygulamıştır ve bu bağlamda, bu iki ülkenin benzerlikleri ve farklılıkları Güney Avrupa refah rejimi çerçevesinde analiz edilmelidir. Bu noktada, inceleme sorusu şu şekilde özetlenebilir: Türkiye ve İtalya'nın evrensel sağlık sistemleri, Güney Avrupa refah rejimi modeli çerçevesinde nasıl karşılaştırılabilir? Bu makalede, İtalyan ve Türk sağlık sistemlerine sağlık hizmetleri sunumu ve sağlık harcamaları olarak iki farklı noktadan odaklanmak istiyoruz. Bu çalışma Ekonomik Kalkınma ve İşbirliği Örgütü (Organisation for Economic Co-operation and Development -OECD) ve Dünya Sağlık Örgütü (World Health Organization- WHO)'nün 2014 raporlarıyla ve ilgili diğer araştırmalar temel alınarak hazırlanmıştır.

Anahtar Kelimeler: *Güney Avrupa refah rejimi, evrensel sağlık reformu, Ulusal Sağlık Sistemi (SSN), Sağlıkta Dönüşüm Programı (SDP).*

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I. INTRODUCTION

From the early 1990s, there has been an ongoing discussion about whether the Southern European welfare regime has peculiarities or not. This debate stemmed from growing statistics and researches on the social policy mechanisms of the four countries; Italy, Spain, Portugal and Greece. It is known that welfare regime typologies are not sufficient in order to categorize the whole structures of social policy in countries, however; they are advantageous to demonstrate possible weaknesses of the existing social policy mechanisms. In this point, the seminal work of Gosta Esping-Andersen (1990) paved the way for classification of welfare regimes based on de-commodification as a central issue. In 'The Three Worlds of Welfare Capitalism', existing welfare regimes were divided into three archetypes categories: the Scandinavian, the Continental, and the Anglo-Saxon model. The Scandinavian regime is a public service state which is based on tax-financed and universality principle, while the Anglo-Saxon model is characterized by residual doctrine in social protection which is also based upon general taxation with means-tested and low benefits. The Continental type is a distributive state; it is financed by 'contributions' from employers and employees in the labour market and it has the notion of work-based social status (Esping-Andersen 1990). In the recent decades, the distinctiveness of Southern European countries has been debated among scholars i.e. Bislev and Hansen (1991), Leibfried (1992), Kosonen (1992), Abrahamson (1992), Petmesidou (1996) and Ferrera (1996). According to Leibfried, the root of the distinctiveness of the Southern European model is originated from the residualism of welfare state and the central role of the Catholic Church and the family; while Petmesidou argued about the peculiarity of clientelism and the strong power of family as a distinctive factor. All of them have added to these three classic categories a fourth, South European model in which the welfare state as a 'semi-institutionalised premise' (Katrougalos, Lazaridis 2003). The misclassification of the Mediterranean states has been criticized that these countries are not a type of an immature Continental welfare regime (Bonoli 1997; Arts, Gelissen 2002). There is also a critical approach from feminist perspective, highlighting of the role of family as a main element and the position of women as a main care giver (Trifiletti 1999; Flaquer 2000; Naldini 2003). On the other hand, the peculiarities of Southern European countries has been accepted as a sub-category of the family of the 'state-corporatist' welfare model by the authors like Esping-Andersen (1999) and Katrougalos and Lazaridis (2003). Because there are two distinguished clusters; the first one Iberian country and Italy and the second one Greece among these Southern countries, they should not be evaluated within the same model i.e. the Southern European model (Katrougalos, Lazaridis 2003).

M. Ferrera's argumentation for this 'South European Welfare Regime' is the frequently referred one because it includes the most determined classification (Castles, Ferrera 1996; Ferrera 1996; Ferrera 1997). With the contributions of other scholars like Rhodes (1997a), Guillen and Matsaganis (2000), there are four determined characteristics for this model: "(1) a highly fragmented and 'corporatist' income maintenance system (2) the departure from corporatist traditions in the field of health care and the establishment (at least partially) of National Health Services (NHS) based on universalistic principles (3) a low degree of state penetration of the welfare sphere and a highly collusive mix between public and non-public actors and institutions (4) the persistence of clientelism and the formation –in some cases- of fairly elaborated 'patronage machines' for the selective distribution of cash subsidies." (Ferrera 1996). In this point, the establishment of NHS with the universalism principle is presented as a determinative factor for the distinctiveness of 'Southern Model' of welfare regime and it is defined as "an original mix of corporatism and universalism" (Ferrera 1997). All four countries in this Southern model had an occupationally fragmented social insurance regime and worker-based health care system rather than as a basic citizen's right. Nevertheless, they reformed these social insurance systems with universalistic principle, tax-

financed and open to all citizens model, in the recent decades; Portugal in 1976, Italy in 1978 and Spain in 1980, respectively. They have also shared the public-private partnership in the provision of health care as another characteristic; “Here, the establishment of a national health service (Italian or Iberian style) has not promoted a strengthening of the public sphere and the crowding out of private provision, but a peculiar collusion of public and private—often with great advantages and profits for the latter.” (Ferrera 1996).

II. THE TRANSFORMATION OF THE TURKISH HEALTH CARE REGIME: TOWARDS ‘UNIVERSALISM’ IN HEALTH

The establishment of a welfare state is related with the level of socioeconomic development, historical and political tradition. In this regard, the evolution of the Turkish welfare regime has shaped with the influence of national state ideology and European welfare regimes and globalization, respectively. In Turkey’s framework, the transformation of welfare regime has been debated by various scholars since the mid-1990s. Turkey has distinct features in the topic of relationship between state, market and family. These explicit characteristics have been interpreted as a similarity with the Southern European model of welfare (Gough 1996; Buğra, Keyder 2003; Grütjen 2009; Duyulmuş 2009). The origin of this argumentation is derived from the polarized social security system and the position of family as a main welfare provision, basically; “When we suggest that Turkey’s traditional welfare regime resembles the Southern European type, in addition to structure of employment, we also have in mind the properties of formal social policy institutions and informal social integration mechanisms.”(Buğra, Keyder 2003). The Turkish pension system has a high degree of polarization and also, relatively, low level of coverage; it has included 41 percent of the population who is above the age of 65 years (OECD 2006). With the establishment of the Social Security Institution (Sosyal Güvenlik Kurumu, SGK) as main governance unit in 2006, the three former social security institutions (Sosyal Sigortalar Kurumu, SSK; Emekli Sandığı, ES and Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu, BAĞ-KUR) were united in the health care provision; however, their payments and regulations were diversified from each other in the topic of pension.

The central role of family is another well-known peculiarity of the Turkish welfare regime with taking into account the number and the size of household. World Bank asserts that “it is difficult to overstate the importance of marriage, family and extended family ties in the Turkish context.” (World Bank 2003). Similar to the South European countries, the importance of family ties and the marriage as an institution have preserved their place in the context of welfare regime; 4.07 is the mean household size in urban areas of Turkey, while 2.6 is the result in the Italian household (World Bank 2005). The number of young people who are living with their families is also analogous with the existing condition among Mediterranean countries; the percentage of men and women who were staying with their parents that are 49 percent and 29 percent in Turkey, 45 percent and 34 percent in Spain, 67 percent and 60 percent in Italy and 48 percent and 33 percent in Portugal, respectively (Grütjen 2009). With the precious contributions of feminist approach, the central role of family in the welfare regimes of Southern European countries has been highlighted since 1990s. The structure of Male Breadwinner Model in the Continental Europe transformed into Family and Kin Solidarity Model in the context of the Southern European countries. In the point of Turkey; the concept of Male Breadwinner Model is valid in the area of social security; however, Family and Kin Solidarity Model is also effective with considering existing ‘dependency’ concept and care policies for elderly, children and babies who are ‘dependent’ to mostly women-care givers from their families.

In the current decade, the Southern European countries transformed their healthcare regimes from occupational and hierarchical based system to universal-right based national

health system; Portugal in 1976, Italy in 1978 and Spain in 1980, respectively. Nonetheless, it is argued that there is also a counter movement within these countries against universalism principle in the health care provision because of its financing and regulating problems and other challenges. In this context, there is other aspect for this ‘similarity’ debate that it is about the recent reform of Turkey in the health care, namely; the Health Transformation Programme (HTP) in 2003. Before this reform package, Turkey’s health care regime could be evaluated within the Bismarkian typology because of its hierarchical and occupation-based insurance scheme. With the establishment of Social Security Institution (Sosyal Güvenlik Kurumu, SGK) as a main regulator and the implementation of General Health Insurance (Genel Sağlık Sigortası, GSS); the Turkish health system has taken a major step towards a universalistic health care provision system, gradually. On the other hand, the domain of privatization and market incentives were also being introduced in health care sector as a result of economic liberalization movement since the early 1980s. In another words, this reform step of Turkey had some similarities and also, it has showed critical differences with the health care reforms in the Southern European countries i.e. Italy.

In the topic of health care regime, there is an ongoing debate that how can we classify contemporary health care systems according to existing welfare regime typologies. These seminal welfare regime classifications of Esping-Andersen have been criticized seriously, because they have obtrusive generalizations about all type of social services and they don’t involve a de-commodification index in health care provision. In this regard, the notion of decommodification index is rearranged with 18 countries under three measures (private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stocks and the percentage of the population covered by the health care system) in order to indicate the reliability of Esping-Andersen’s decommodification method based upon the labour market and income maintenance (Bambra 2005). Claire Bambra’s health care decommodification index has both convergences and divergences with Esping-Andersen’s results; especially, in the classification of Canada, UK and New Zealand. Within the Turkish context, Tuba Ağartan’s article reveals the de-commodification index of Turkey’s HTP under three dimensions (private health expenditure as a percentage of GDP, private hospital beds as a percentage of total bed stocks and number of private and public hospitals) and the marketization effect over this index since 2003; it asserts that “Turkish healthcare reform illustrates how particular dynamics of marketization in late-developing and transition countries may increase inequalities in accessing healthcare services.” (Ağartan 2012).

Given the cases above, the Turkish welfare regime is accepted as an example of the Southern European model because of its structure in welfare provision. In this regard, Turkey’s healthcare regime has an ongoing transformation programme since 2003 and it has been debated from the point of de-commodification, marketization and universalism principle, basically. To compare and contrast with the Italian healthcare reform in 1978, Turkey’s health care provision will be analysed also in the point of the provision of health care and the health care expenditure. In this way, similarities and differences among the Italian and the Turkish health care provision can be debated on equal basis.

Since 2003, the health care system of Turkey has encountered with winds of remarkable reforms, after the vulnerable coalition government periods, The Health Transformation Programme (HTP) was presented by the Justice and Development Party (JDP) as a ‘window of opportunity’ in order to solve well-known troubles within the existing unequal health care regime of Turkey (Ağartan 2014). The former Bismarkian health care regime of Turkey had four types of inequalities; inequalities in health care services, inequalities among social insurance funds (SSK, ES and BAĞ-KUR), inequalities between ‘users’ of social insurances and ‘outsiders’ (the Green Card implementation) and lastly, inequalities in the expenditure of out of pocket (Yılmaz 2013). The non-egalitarian structure of former social insurance

scheme represented the polarized condition of labour market; there was a hierarchy among individual and state contributions to SSK, ES and BAĞ-KUR and also, there were a fragmented administration of benefit package, premium rates and health care services as well as their qualities and efficiencies.

This occupational-based health care provision of Turkey was presented as a major public problem and the requirement for reformation of health care system was labelled as one of the prior actions of this new government (JDP 2002; MoH 2003). In this point, HTP's major ideals include that the establishment of compulsory universal health insurance (Genel Sağlık Sigortası, GSS), the foundation of one-central social insurance fund (Sosyal Güvenlik Kurumu, SGK), the consolidation of Ministry of Health, the reorganization of health care services delivery, and the separation of financing section from this delivery part. That's why; HTP has purposed to make comprehensive reforms in the health care finance, regulation and delivery areas by the help of increasing in the role of private sector as a new emerging actor. The aim of universalism in the health care provision system has been stressed as one of the major ideals in order to provide a universal health insurance for 'poor and uninsured' population within the former system: "Our party deems the fulfilment of public health services as one of the crucial elements of the social State concept. The social security umbrella shall be established so as to cover the entire population." (JDP Party Programme 2016).

On the other hand, HTP paved the way for critical arguments on marketization, commodification of health care and new inequalities among citizens. There are similar discourses in HTP and the former reform initiatives since the beginning of 1990s; stressing of high infant and maternal mortality rates, inequality in accessing to primary care, low level of coverage (32% of total population in 2002), inefficiency of administration in both public and SSK hospitals, inadequacy of health care resources i.e. doctors, nurses and auxiliary staffs and rising costs and expenditures with a fiscal crisis (Ağartan 2014). At the same time, HTP's changes could not break the existing social insurance based health care finance regulation and the establishment of SGK as a center didn't eliminate inequalities in payments and contributions of the beneficiaries. In this regard, HTP's solution involves an increasing role of private hospitals as a partnership between public and private sectors; it brings the reorganization of state as a main coordinator and directing the activities of private sectors in the health care provision. As Yılmaz states that "the HTP has replaced occupational status as the primary origin of inequalities in access to health care with income." (Yılmaz 2013).

III. THE ITALIAN HEALTH CARE REGIME: 'THE SECOND IN THE WORLD'

The Italian National Health Service (Servizio Sanitario Nazionale – SSN) was established in 1978 in order to shift the former in-egalitarian health insurance fund system following the Second World War with an aim of right-based universal health care provision to all citizens, financed by general taxation (Law no: 833/78). The essential political coalition for this health care reform was formed in between the Christian Democrat Party and the Communist party within an exceptional period (McCarthy 1991). The main aim of the SSN could be summarized as creating of a uniform and tax-financed health system with the coverage of entire population in order to provide emergency, primary, secondary care, pharmaceuticals, specialist outpatient care, integrated care, home care, public health and occupational health services. The SSN took the British National Health Service as an example; however, it was rearranged with respect to Italy's decentralization process which was dated back to the constitution of 1948 and the formation of duly-authorized regions in the 1970. After that point, the SSN was managed in the three levels; central, regional and local level. As the main coordinator, the Ministry of Health has been authorised in the issues that the determination of the NHS health targets (the National Health Plan), the management of the National

Institution for Scientific Research (IRCCSS) and the National Institute of Health and the administration of financial resources among different regions. At regional and local level, regional governments and parliaments are responsible for ensuring their spending responsibility in health care services under three branches (emergency, primary and secondary care in both public and private hospitals) as well as protecting their quality and increasing their efficiency (HiT Summary: Italy 2009).

Since the mid-1990s, there has been an ongoing debate over ‘federalism’ in Italy and by the help of Law Bassanini reform in 1997; the transference of authority from the central government to the regional governments was finished, gradually. With the market-oriented 1992-93 and the innovative 1999 health care reforms packages; both financing and spending administrations were given to the regional level authorities as a result of structural and financial crisis of 1978 health care reform (Maino 2001). This policy of ‘fiscal federalism’ and decentralization include 21 regions and 2 autonomous provinces with a high degree of financial and organizational independency in their realm of authority. The central government’s political and fiscal authorisation over allocation of resources is limited at a certain point with reorganization of ‘steering’ role of the state. In this regard, the financial resources of SSN is mostly provided from national and regional taxations (78% of total health expenditure) and out of pocket payments as supplementary payments (18% of total health expenditure). On the other hand, there is a critical issue which have been questioned since the implementation of these reforms; the possibility of regional variations in the organisation and provision of health services in between the Northern and the Southern part of Italy (France et al. 2005; Ricciardi et al. 2009; Toth 2013; WHO 2014a; OECD 2014a). It is highlighted that “this regional variation in health care reflects (and exacerbates) differences of contextual, political, economic and cultural factors as well as differences between regional health systems.” (Ricciardi et al. 2009).

IV. THE PROVISION OF HEALTH CARE IN THE ITALIAN AND THE TURKISH HEALTH CARE SYSTEMS

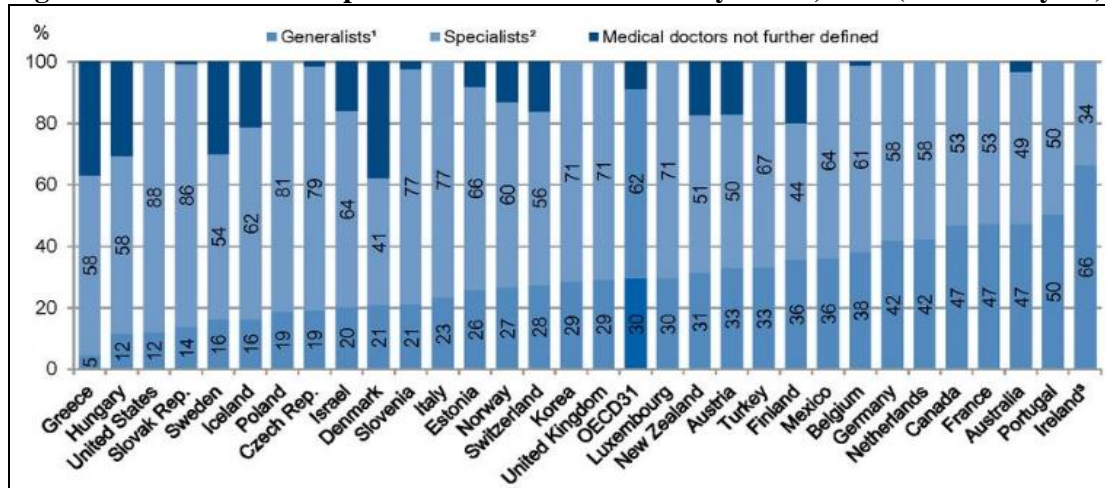
In this paper, the main target is to analyse the Italian and Turkish health care provisions under two dimensions: the provision of health care and the health care expenditure, respectively. From the point of ‘universalism’, the Southern European welfare regime discourse in the health care provision is taken as a starting point and in this regard; the place of Turkey and Italy will be debated within this model. To determine the provision of health care, various indicators can be taken into account such as the current situation of primary health care services, the number of medical workforce and the number of hospitals with their bed capacities.

As a point of origin, the contemporary condition of primary care services is compared; the primary care system means that the first place of relationship between citizens and local health services. In both cases, the primary care services serves in many braches including diagnosis, treatment, preventive care, monitoring of parent and child health and following of chronic diseases. It is conducted primary care physicians (PCPs) in Italy and family physicians (FPs) in Turkey at the local level by free of charge and the requirement of enrolment of this systems’ database.

The Italian health care system has a well-known primary care services network (Local Health Authorities – ASLs) despite of the fact that there has a growing ageing population (the third highest among the OECD countries). This demographical change in ageing population is a serious challenge against the existing primary care services in terms of health care costs and expenditures. According to the OECD health review of 2014; there was an ongoing increase in the average number of patients who had appealed to primary care

services in between 2001 and 2009; 3.4% and 9.4% for GPs (Guardia Medica) and paediatricians, respectively. As a result of this tendency, GPs and paediatricians registered almost 1500 and 800 on their patients lists; each GP's patient average was 1.134, while each paediatrician's patient average was 857 on their registration lists in 2009. That's why; there were initiatives for reorganization of community and primary care services; in 2009, there were 711 health districts; however, the number of health districts in each ASL is changeable in each region (OECD 2014a). In the SSN; the main role of the primary care physicians is that acting as a 'gatekeeper' to the secondary care; patients must have a referral from their PCPs in order to appeal a specialist, outpatient hospital care as a secondary care. By this way, the intensity of hospitals has been reduced and the management of patients has been conducted by PCPs with the contribution of this medical referral co-ordination system. The numbers of PCPs and GPs were estimated that there were 0.76 GPs per 100.000 inhabitants and 0.91 paediatricians per 100.000 children aged between 0 and 14 years old. On the other hand, the unbalanced situation of the medical workforce attracts our attention, undeniably; GPs composed of 23% of all physicians, while the OECD average was 30%. Under these conditions, the patient satisfaction about the Italian primary health care provision was measured as relatively high; the quality of primary care services in SSN is a corner stone in sustainability of this system according to patients' evaluations (OECD 2014a).

In Turkey's framework, the requirement for establishing of well-coordinating primary care services is always a recognized problem and before the Health Transformation Programme (HTP), there were also several attempts and implementations to ensure the first-level health service to all citizens. Nevertheless, these attempts could not be evaluated as effective as the Italian case, obviously. As a result of HTP's rebuilding policy, in both supply and access to primary health care services has developed in the issue of especially maternal and child health care and preventable infectious diseases among risk groups since 2003. The monitoring of chronic diseases including heart, kidney diseases and diabetes and the administrating of home care are remarkable improvements in HTP. There is a limited independency of family medicine (FM); the FM team has composed of one family physician, nurses and assistants who have worked with a list of registered patients within their authorized areas under the administration of the Public Health Agency of Turkey in each of the 81 provinces. In this regard, the number of primary health care centers rose 28.5 centres per 100 000 population in 1994 to 44.4 centres per 100 000 in 2006 (OECD 2014b). At the same time, the primary care applications advanced from 69 million to 254 million in between 2002 and 2012; like in the Italian case, there is an ongoing demand for primary health care services, yet, Turkey's results are more outstanding in a certain extent (OECD 2014b). As another difference, the number of Turkey's medical workforce in the primary health care was comparatively higher than Italy; the number of FMs composed of 33% of all physicians, while Italy remained 23% of all physicians in this topic (Figure 1). Nonetheless, the number of family physicians was around 2.500 and the number of GPs was 10.000 in Turkey. Also, the doctors of Turkey have struggled with the increasing demand in the primary care services: 3.500- 4000 patients per physician on average in Turkey (OECD 2014b), on the other hand, Italy had 1.134 as a GP's patient average and the average of OECD were 2000-2500 patients per physician (OECD 2014a). Given the cases above, the patient satisfaction rates about the quality of primary care services tended to increase like in the Italian case: it rose from 41% in 2000 to 71% in 2008 (OECD 2014b).

Figure 1. Generalists and Specialists as a Share of All Physicians, 2011 (or nearest year)

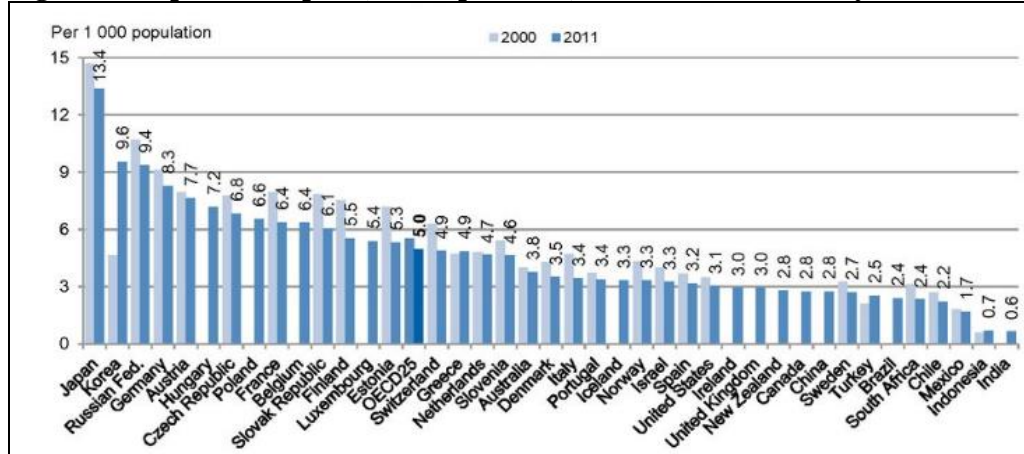
Source: OECD Reviews of Health Care Quality: Turkey (2014) <http://www.oecd.org/turkey/oecd-reviews-of-health-care-quality-turkey-2013-9789264202054-en.htm>, Last Accessed: 26.12.2016.

The number of skilled medical workforce is another essential indicator to determine the level of a health care provision at both primary and secondary care. In this regard, the quality of medical education and training in both Italy and Turkey should be kept high; their medical education have been evaluated as ‘qualified’, but it should be protected. The average number among OECD countries was 3.2 doctors per 1.000 population and 8.8 nurses per 100,000 population. In this regard, Turkey’s lower overall levels of doctors and nurses lead to disruption in both primary and secondary health care services; the number of practicing doctors per 1,000 population was 4.0 in Italy (OECD 2014a), while this number was 1.7 doctors per 1,000 population in Turkey (OECD 2014b). Turkey’s human resources in medical workforce have always been criticized because of its shortage; Turkey has the second lowest number of doctors among OECD countries. On the other hand, this result has tended to change since 2003 with the transformation in health programme; the annual growth in the number of doctors was measured as 5.4% a year between 2000 and 2009, while the average number of annual growth in the number of doctors among OECD countries stayed 1.7% a year (OECD 2014b). As a similarity in the medical workforce topic, the number of practicing nurses in both Italy and Turkey were lower than the OECD average; the number of practicing nurses per 100,000 population was measured as 6.3 in Italy (OECD 2014a), this result was even worse in Turkey: 1.7 nurses per 1.000 population. (OECD 2014b). Comparatively, the rate of nurses to physicians was also low in both Italy and Turkey; at 1.6 nurses per physician in Italy and 1 nurse per doctor in Turkey (the lowest nurse to physician ratios in the OECD) (OECD 2014b). That’s why; the serious concern about inadequacies of nurses caused to increase in the nursing education programmes in both Italy and Turkey at the level of university as well as high-school.

The Turkish and Italian hospital sectors consist of both publicly and privately owned and run institutions. The Ministry of Health hospitals comprises of the public hospital sector and their ratio was 59% of all hospitals and 60% of all hospital bed capacities in Turkey. Private hospitals perform about 34% of all hospitals, and 14% of all hospital beds (OECD 2014b). On this issue, Turkey has one of the lowest capacities of hospitals and hospital beds among OECD countries; however, she has the fastest growing ratios especially in private sector in both indicators. The average number of hospitals for per million populations among OECD countries was measured as 29.0; this rate was 19.5 in Italy and it was 19 in Turkey. On the other hand, the number of hospital beds was 3.4 in Italy and it was 2.5 in Turkey, while the

OECD average was determined as 5.0 (Figure 2). In this point, it can be seen that Italy and Turkey has similarities in the topic of hospital and hospital bed ratios; two of them remained the average number of OECD. Nevertheless, Italy's health policy is based on the expansion of primary health care and the avoiding of hospitalization and that's why, these results of Italy can be evaluated as an admissible ratio. In there, the growth in the public and private hospital sector in Turkey should be questioned because the increasing number of private hospitals reached upon 90% in between 2002-2011, while it stayed in 10% for public hospitals.

Figure 2. Hospital Beds per 1,000 Population , 2000 and 2011 (latest year available)



Source: OECD Reviews of Health Care Quality: Turkey (2014). <http://www.oecd.org/turkey/oecd-reviews-of-health-care-quality-turkey-2013-9789264202054-en.htm>, Last Accessed: 26.12.2016.

V. THE EXPENDITURE OF HEALTH CARE IN THE ITALIAN AND THE TURKISH HEALTH CARE SYSTEMS

In contrast to the tax-funded universal-right based Italian health care provision policy (the National Health Fund), the Turkish health system has adhered to the former system: it has been funded by contributions from employees, employers and state with different payment levels. This obvious difference among Italy and Turkey constitutes the main diversified point for this discussion because the policy of financing mechanism has a dominant power over the idea of universal health care provision to all citizens and the sustainability of the universal health care regime to a large extent. The universal health care provision means that the principle of a common package of benefits for all citizens. Undoubtedly, this difference in the finance policy has influenced to the total expenditure on health per capita as well as the total expenditure on health as % of GDP; Italy had the ratio of the total expenditure on health capita 3.239, while Turkey's result was measured as 1.036 in the same year. In another words, Italy's total expenditure on health as % of GDP was that 9.2 and Turkey reserved 5.4% of their GDP for health expenditure. The OECD average was that 9.3 (WHO 2014ab).

The establishment of national universal health insurance influences to increase the level of coverage of the population in a direct way. In this issue, the Italian health care provision offers to compulsory universal coverage and it doesn't allow leaving out this social health insurance system from the late 1970s; the level of coverage was up to 93% of whole population in Italy. The insurance program is also available and free of charge in terms of legal immigrants since 1998 and with this change, their level on coverage was estimated nearly 98% of all population (HiT 2014). On the other hand, Turkey's official data for the

level of coverage is noteworthy in order to follow up the change in coverage numbers; before the HTP, the level of coverage was estimated as 67.2% of the population (33.4% of the population was covered by SSK, 5.1% by ES and 11.7% by BAĞ-KUR, while the Green card's percentage was 8.6.) (Ağartan 2012). When it came to 2010, the estimated coverage level of the Turkish health system was measured as 96% of the population (83% of the population had national health insurance and 13% of the population was covered by the Green Card.) (Ağartan 2012). All in all, this blowing up in the coverage rates can be interpreted as another successful result of the national universal health insurance program in Turkey.

The issue of out-of pocket payments (OOPs) are the last point which I would like to highlight in this research paper. Out-of pocket payments are paid directly by users who appeals to this service and they are not included in the payments of insurance systems, in this regard; the increasing or decreasing of out of pocket payments can be useful in order to look into these existing universal health insurance based systems within Italy and Turkey. Italy has two main types of out-of-pocket payments; demands side cost-sharing as the first type and direct payment as the second type. In economic terms, the ratio of OOPs was given as 18% of total expenditure and this ratio of OOPs spending reduced 5.1% in between 2000 and 2011 (OECD 2014a). The OECD average for OOPs rate was 20% of total health expenditure and the reduction ratio among OECD countries for OOPS was determined as 1.2%. From Turkey's side, the spending of OOPs was much higher than other OECD countries (19.8%), however, these reforms initiatives have influenced over the reduction ratio of OOPs since 2003; it was 10.3% reduction in out-of pocket expenditure in between 2000 and 2011 (OECD 2014b).

VI. DISCUSSION AND CONCLUSION

In this research paper, I endeavoured to compare Italy and Turkey's health systems on the universalism principle of the Southern European welfare regime model. The provision of health care and the health care expenditure are my two dimensions because they are remarkable indicators which can represent not only the level of spending on health care, but also the level of qualified and available health care service to all citizens. Italy's National Health System (SSN) was established in the 1978; this system has based on 'decentralization' doctrine and the role of regional governments has maintained to expand after the 2001 constitution reform. This decentralized structure of Italy's health care system has paved the way for debating inequality of resource distribution among Northern and Southern regions. On the other hand, Turkey's health care regime has been administered by the authority of Ministry of Health, even if, there has been given a partial financial authority to the family medicine center and public hospitals after the Health Transformation Program (HTP).

As a result of both decentralization and universalism policy, the Italian health care system adopts the expansion of qualified primary care for all citizens; these primary care centers act as a 'gatekeeper' within this system. At the same time, the purpose of Turkey's reform package is also the development of primary care services networks for everyone's access and the improvement in gatekeeper mission of primary health care services; yet, this reform has acted together with the hospitalization wave and the gatekeeping mission is not be successful as well as the Italian case; the number of hospital for per million population is nearly similar among Italy and Turkey. The similarity between hospital beds attracts the attention; Turkey's improvement in this case should be regarded carefully because of the growing in the ratio of private hospitals; this trend in marketization makes inroads into discussion for the sustainability of the national universal health insurance program and the protection of qualified public health care services. All in all, it can be stated that the Italian primary health

care services is more inclusive and more developed from the Turkish one in terms of accessibility, the ratio of physicians, nurses and patients; however, both of them should enhanced their qualified medical workforces in order to sustain their health care systems without possible shortages. It is known that the quality of medical workforce is non-negligible part of the universal health care service provision.

In the second place, the health care expenditure levels of these two countries are diversified from each other as well as their population and gross national income per capita; Italy's expenditure on health as % of GDP is nearly 9.2; however, Turkey's ratio is lesser than both the level of Italy and the average number of OECD countries. Nevertheless, the most prominent division among these two systems derives from their funding policies; the Italian health care system is based on the universal tax-funded regime, while Turkey's finance resources have been supplied from contributions of state, employees and employers in different payments' ratios. With the introduction of HTP, the level of out-of pockets have tended to decrease and it has approached to the average number of OECD; however, there is a new dimension in there that is 'additional payments'. This difference of the Turkish health care regime is a challenge for adhering to the national universal health care insurance and also, it is a serious threat for sustainability of universalism principle in health. The level of coverage in health has reached upon 96% of all population in Turkey; this ratio is pretty much same in the number of Italy. In this context, it can be asserted that there is a striking improvement in the coverage ratios in Turkey; but the policy of contribution-based in finance has still remained as an obstacle in the enhancing of universal health care provision.

Under the light of provided backgrounds, the universalism principle in the Italian health care regime can be accepted as prospering one because it adopts tax-funded finance policy and also, the condition of primary health care services is quite better than the Turkish primary health care services in terms of the provision of health care. In this regard, the health care report of Italy can be evaluated as full-converged with the health care regime of the Southern European welfare regime model. On the other hand, Turkey has also made progress in the issues of primary health care services, hospital capacities and medical workforces as well as their expenditure levels on health. Nevertheless, their developments are not being sufficient to be counted within the Southern European health care regime because it is based on the contribution-based funded finance policy, rather than the tax-funded universal regime. It should be rearranged the financing policy and also, the attempt of marketization should be limited to prevent possible inequalities based on income.

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