Exploring Patient Experiences of the Internal Market for Healthcare Provision in Turkey: Publicness under Pressure

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Abstract

The establishment of internal markets for healthcare provision in publicly-funded healthcare systems brings forth a number of new regulatory challenges. During the 2003 healthcare reform in Turkey, universal health coverage (UHC) was implemented concurrently with the establishment of an internal market for service provision, resulting in an increase in private sector activity. In this context, this paper explores how, in the Turkish case, the macro-level adoption of an internal market model for healthcare provision has shaped patient experiences at the micro-level in their ability to receive treatment in private hospitals offering publicly-funded services (PHOPS). It also examines the influence of the internal market on the realised publicness of healthcare services in Turkey. Data for the study were obtained from patient complaints that appeared on a private online platform and 20 patient interviews. These showed that patients sometimes face significant challenges, including pressure to make informal payments, when accessing their entitlements, which is evidence of the erosion of publicness in a hybrid healthcare system. These challenges emerge from information asymmetry between patients and providers; a large space for PHOPS to manoeuvre when deciding to register patients as insurance holders or private patients; and the ineffective public regulation of the internal market.

Keywords: healthcare policy; hybrid healthcare system; internal market; informal payment; publicness; regulation

List of terms: Diagnosis-related groups (DRGs), emergency services (ER), Health Transformation Program in Turkey (HTP), out-of-pocket (OOP), private health insurance (PHI), private hospitals offering publicly-funded services (PHOPS), public-private partnership (PPP), social health insurance (SHI), Social Security Institution of Turkey (SSI), universal health coverage (UHC)

1. Introduction

Private sector engagement in social services in general and healthcare provision in particular has been extensively observed in welfare systems, especially since the late

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1970s. This trend symbolizes the latest phase in public-private partnership (PPP) solutions to achieve universal health coverage (UHC), as reflected in the United Nations Sustainable Development Goals. A number of studies (Øvretveit, 2003; Saltman, 2003; Tuohy, 2012) demonstrate that putting this policy paradigm into practice has resulted in a greater degree of interpenetration of public and private sectors and has blurred boundaries between these sectors.

The establishment of internal markets is one of the policy instruments that have been employed to put this broader trend towards PPPs into practice. Internal markets are aimed at bringing together the equity that public financing provides and the efficiency and choice that competitive private provision produces in organizing social services (Le Grand, 1991). Increasing public-private linkages in publicly-funded healthcare systems requires more sophisticated forms of state regulation (Saltman, 2002) of private providers, particularly with respect to ensuring compatibility of private sector profit-seeking motives with the UHC ethos of publicly-funded healthcare systems. The need for state regulation has increased as internal markets in healthcare have strengthened the position of private providers in healthcare systems and privileged their interests (Checkland et al., 2009).

Internal markets do not, in theory, pose a challenge to the publicness of social services, but in practice, they may undermine realised publicness. Realised publicness is defined as 'the realization of public values demonstrated by organisational behaviour or outcomes' (Moulton, 2009: 891). This understanding of publicness goes beyond descriptive macro-level indicators (e.g. the weight of the public sector in terms of financial resources and ownership) and addresses the extent to which private organisations pursue public goals and contribute to the realisation of public outcomes at the micro-level (Moulton, 2009: 890). The larger social context where these organisations operate has a significant influence on shaping their behaviours. In this regard, Taylor-Gooby (1999) argues that a regulatory environment which garners trust between providers and patients is a must for well-functioning welfare markets in healthcare. He (1999: 98-99) also warns that behaviours that undermine this framework may destroy trust, which can lead to an erosion of social citizenship. It is against this background that Denis et al. (2015) call for an examination of the regulatory environment in hybrid public systems at multiple levels from the varied perspectives of providers, regulators and patients. The regulatory environment has emerged as an important domain for studying publicness in healthcare policy research.

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The Turkish healthcare system presents an interesting case for examining the regulatory environment for two reasons: First, it is a new hybrid healthcare system—using Schmid et al.'s (2010) concept. Turkey's Health Transformation Program (HTP), a comprehensive healthcare reform launched in 2003, resulted in a shift of focus from public provision to mixed provision and established an internal market for healthcare providers while keeping the social health insurance (SHI) financing model intact. Policymakers framed this shift as a movement towards UHC that increased patient choice and obtained better cost-containment (The Ministry of Health, 2012). Second, previous studies (Helderman et al., 2012; Rothgang et al., 2005; Schmid et al., 2010) suggest that the specific form that healthcare regulation takes is shaped by distinct national contexts. A study of the underexplored Turkish case will offer valuable insights into how an internal market has been implemented in a specific country context. The purpose of this paper is therefore to explore how the internal market for healthcare provision has shaped patient experiences of accessing treatment in private hospitals offering publicly-funded services (PHOPS).

2. The regulation of hybrid healthcare systems

Following tighter interpenetration of public and private sectors in healthcare with market-oriented reforms (Øvretveit, 2003; Saltman, 2003; Tuohy, 2012), the literature reflects a trend towards increased state regulation (Helderman et al., 2012; Kjekshus and Veggeland, 2011; Rothgang et al., 2005; Schmid et al., 2010; Van de Ven et al., 2013; Walshe, 2002). Jacobson defines healthcare regulation as 'both legislative and regulatory oversight of the healthcare system' (2001: 1166) and views regulation on a spectrum that ranges from the public sector replacing the market to the public sector facilitating the functioning of the market.

One group of studies emphasizes that public regulation of the private sector in healthcare can fail—and if it fails, it can have negative implications for access. For example, evidence from the U.S. indicates how a state with a strong historical legacy of market regulation (Moran, 2010) can systematically fail in regulating the healthcare sector to achieve cost-containment and UHC (Jacobson et al., 2011). Another example is Durham et al.'s (2015) study on Haiti, which exemplifies how failed stewardship of the public sector has led to a privatized and largely unregulated healthcare market.

Another group of scholars, however, argues that public regulation might work under certain circumstances, and when it works, it can ensure that the private sector

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pursues public goals. Nachtnebel et al. (2015) find that government purchasing of services from the private sector to fill service gaps is effective, especially where the stewardship capacity of the public sector is strong. Van de Ven et al. (2013) suggest that managed competition in healthcare could bring efficiency and affordability if certain preconditions are met: specifically, if consumers are well-informed and free to choose, if competition regulation is in place to prevent risk selection and free riding, if access to basic care is guaranteed, and if service quality is effectively monitored.

Studies on governmental subcontracting of services from private providers focus mainly on the relationship between public and private sector actors (e.g., Bennett and Mills, 1998; Greasley, 2018). Bode (2019) offers a refined analysis of the coexisting accountability pressures under which non-profit and municipal hospitals operate in Germany and the implications of the ways in which hospitals tackle these pressures on the publicness of healthcare provision. For Bode, these types of hospitals, on the one hand, constitute public services-providing organisations that are politically accountable in their pursuit of public goals. On the other hand, with the New Public Management-oriented reforms, non-profit and municipal hospitals face market accountability pressure that at times conflicts with their political accountability. He then (2019: 15) concludes that market accountability concerns generally override political accountability in the day-to-day functioning of providers.

The question of how patients and conditions for accessing care are influenced by internal markets in healthcare remains unanswered (as acknowledged in Bode, 2019; Powell and Miller, 2014). One entry point for examining the influence of internal markets on patient experiences and the publicness of the system is the information asymmetry between patients and providers. Information asymmetry in healthcare markets has long been a significant problem that results in market failures (Arrow, 1978). Risk pooling in collective forms of healthcare financing (Beveridge, 1942) and in private healthcare insurance (Arrow, 1978) has been a key response to this problem. The coexistence of multiple healthcare financing arrangements in many countries today may have exacerbated this problem. Sepehri et al.'s study (2003) on the financial protection of patients after healthcare restructuring in Vietnam, one of the few exceptions in the literature, demonstrates that failed regulation can lead to financial abuse of patients by private providers.

Informal payments constitute another entry point for examining patient experiences of the internal market. Such payments have long been associated with

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public providers in developing and transition countries (e.g., Balabanova and McKee, 2002; Ensor, 2004; Lewis, 2007; Mcmenamin and Timonen, 2002), but scholars overlook the occurrence of informal payments to PHOPS in internal market contexts. Gaal et al. (2006: 276) offer a comprehensive definition of informal payments: ‘a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to healthcare providers for services that the patients are entitled to.’ This definition is useful in spotting informal payments in internal markets as indicators that publicness is being undermined.

Drawing on the abovementioned insights from the literature, this study uses information asymmetry and informal payments as gateways to studying the effects of internal markets on the publicness of the Turkish healthcare system.

3. The Turkish hybrid healthcare system

Turkey adopted an SHI model to finance its curative healthcare services in the 1940s, which has been complemented since the 1990s by a tax-financed component for the poor—arguably defined as those left out of formal employment. The public sector was the dominant player in healthcare provision until the early 2000s. The 2003 health system reform (the HTP) aimed at achieving UHC while increasing private provision with the same reform (Agartan, 2012).

Informal payments were embedded in the pre-reform Turkish healthcare system and undermined equity in access (Tatar et al., 2007; Özgen et al., 2010). This formed the rationale for the HTP to eliminate unethical practices in public hospitals such as physicians asking for extra money from patients to carry out standard tasks. In the pre-reform period, one-fourth of out-of-pocket (OOP) payments were informal (Tatar et al., 2007), and most informal payments in the public sector were directed to physician services (Tatar et al., 2007: 1037-8).

The HTP gradually increased the weight of public funding in the financing of healthcare from 71 per cent in 2003 to 78 per cent in 2015 (OECD, 2019). By making SHI compulsory, a macro-level change, the reform achieved UHC. Ökem and Çakar (2015: 1159) suggest that the HTP eliminated the pre-reform problem of informal payments, thus improving equity in access.

Another macro-level change was the establishment of an internal market for provision. With the reform, the Social Security Institution (SSI), the single-payer,

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started purchasing services from private providers, the majority of which, in the Turkish context, are commercial hospitals. If private providers are willing to offer public services at the SSI-determined reimbursement rates, they sign an annual service contract with the SSI. A service contract may include all services in the hospital or cover only specific specialist services or services by specific physicians. The private hospitals that sign a contract with the SSI are characterized as PHOPS in this study, both to emphasize the public funding for their services and to distinguish them from other private providers that do not offer publicly-funded services.

Reimbursement by SSI to PHOPS is based primarily on diagnosis-related groups (DRGs); exceptions, which include emergency services (ER) and oncology services, are on a fee-for-service basis. The reform has placed SSI reimbursement for PHOPS services at the centre of the controversy in public-private relations in healthcare provision (Yilmaz, 2017). PHOPS representatives started complaining in the 2010s about the low rate of SSI reimbursement. Three consecutive ministers publicly acknowledged that SSI rates for private hospital services needed to be increased (Durham et al., 2015; Medikalnews, 2017; Medimagazin, 2017), and rates were raised modestly in 2018 (Medimagazin, 2018). The use of the DRG reimbursement model and the freezing of SSI rates for almost a decade forced these providers to make the best of economies of scale, which resulted in market concentration (Yilmaz, 2017: 212).

Parallel to the establishment of an internal market, the reform introduced flat-rate co-payments and floating co-insurance for PHOPS. The SSI imposes a cap on the rate of co-insurance that PHOPS can charge. The calculation of the exact amount of co-insurance is based on SSI rates. The cap on co-insurance also varies according to where the provider ranks in the quality classification of private hospitals, which is determined by the Ministry of Health. Notably, in the early years of this practice, the cap was kept at a low level (30 per cent of the SSI rates for the highest-ranking PHOPS), but it was increased steadily in subsequent years and reached 200 per cent in 2013 (Yilmaz, 2017).

Because there is no functioning referral system, patients can directly apply to hospitals and are free to choose between public hospitals and PHOPS. However, since the integration of private hospitals into the SHI plan in 2005, it has not been easy for patients to access reliable information about which private providers have contracts with the SSI, the specific services covered in these contracts, or the legally permitted rates of co-insurance. Patients' limited access to such information was not particularly topical in the early stages of the reform, as the rate of co-insurance was quite modest,

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but with a substantial increase in co-insurance rates over time, the issue has gained prominence.

The complexity of internal market regulations has produced growing information asymmetry between patients and providers. To facilitate patient access to information, the SSI launched a website designed to inform patients about the permitted rate of co-insurance that private hospitals can charge (SSI, n.d.). In addition, contracts between the SSI and private providers (SSI, 2018) set out conditions that providers are required to comply with and specifies the penalties in case of noncompliance. The SSI, for example, requires providers to display a visible sign indicating the permitted rate of co-insurance, and PHOPS must provide a receipt that details all services rendered to the patient and the total amount of co-insurance paid. Overcharging incurs a fine equal to five times the overcharge. The effectiveness of these measures, however, is still uncertain.

Another macro-level change of the HTP was prompted by a populist executive decision in 2010. It prohibited private hospitals from charging co-insurance for ER, intensive care, burn injury treatments, cancer treatments, neonatal care, surgical operations for congenital anomalies, haemodialysis, cardiovascular surgical operations (with specific restrictions), and cochlear implant operations (SSI, 2017). The SSI started reimbursing these services. The government's decision to include private ER services in the SHI plan was met with a great uproar from private hospitals and sparked a debate on the definition of emergency conditions (Medimagazin, 2010).

To regulate patient access to ER services in private hospitals, the SSI (2010) defined emergencies as medical conditions that require 'immediate medical treatment and/or an operation within the first 24 hours or if the treatment is not provided immediately or in case of transfer to another health institution, the situation could result in increased risk of death and/or lasting damage to health'. To ensure private sector compliance, the SSI (2011) introduced a new regulation requiring private hospitals to inform patients when the emergency ends and to ask patients to sign a document acknowledging the end of the emergency. No evaluation is yet available to evidence the effectiveness of this regulation, although patient complaints have appeared in the national media (e.g., Erat, 2018).

Even though the reform increased the weight of public financing in healthcare, recent increases in voluntary private health insurance (PHI) coverage and the share of OOP payments in healthcare expenditures warrant an explanation here. First, the take-

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up of PHI rose from one per cent of the population at the beginning of the reform to almost seven per cent in 2017 (OECD, 2019). Optional supplementary private health insurance was introduced in 2008 to protect citizens from facing high levels of co-insurance in PHOPS, but take-up remains less than one per cent (SAGMER, 2017), which indicates that the recent increase in PHI take-up has not been due to supplementary health insurance membership. Second, the share of OOP payments in total healthcare expenditures never fell below the 15-per cent threshold throughout the 2010s and reached 17.4 in 2017 (OECD, 2019).

Three factors may account for the increase in the share of OOP payments: co-payments for public and private hospital services, co-insurance for PHOPS, and informal payments. The first factor is discussed by Erus and Aktakke (2012), who found that the ratio of households with non-zero OOP expenditures increased with the reform due to the introduction of flat-rate co-payments. Second, for patients, the internal market for provision may have led to an increased reliance on OOP payments to finance co-insurance. In fact, a substantial increase was observed in the share of private providers: from five per cent of patient applications in 2002 to 20 per cent in 2015 (Yilmaz, 2017). Third, as the present study demonstrates, the reform failed to abolish informal payments; it simply generated a shift from informal payments to public providers to informal payments to PHOPS.

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4. Methods

The article is a qualitative exploratory study on patient experiences of the internal market for healthcare provision in Turkey. It does not claim representativeness or generalizability of its findings. The overall incidence of access problems, which this study highlights, is unknown.

Talking with patients about their experiences with PHOPS in general and about informal payments in particular was not easy, as the regulatory framework of the internal market is complex. To determine the lawfulness of the payment requested, for example, patients have to know the following: whether a particular hospital, service, or physician has a contract with the SSI; how much co-insurance a PHOPS is authorized to charge; the details of services received; and the exact amount of co-insurance one is required to pay. Researchers can employ two strategies to explore the issue at hand: collecting available complaints about the issue through found data and interviewing

patients who have recently used services offered by PHOPS. This study employs both strategies.

First, a qualitative analysis was conducted on patient complaints appearing on a private sector-run online platform in Turkey (*Sikayet var*, 'I have a complaint' in English) between December 2017 and May 2018. This platform was established in 2001 to provide customers with a virtual space to share their complaints with fellow customers and to receive prompt responses from companies that are the focus of the complaint. The platform operates in Turkish on a free-of-charge membership basis, and all complaints are monitored before they are published online. Although patient complaints are helpful in identifying the diverse experiences of patients with PHOPS, the data suffer from self-selection bias. Despite this limitation, and given the difficulty in collecting data on the issue under consideration, patient complaints on this platform provided a good starting point for identifying complaint patterns. Between December 2017 and May 2018, twenty-two patient complaints were posted online about PHOPS requests for unjustified payments, all of which are included in the analysis. Half of the complaints were posted from Istanbul, and the other half came from seven other metropolitan cities. The most frequent complaints (nine out of 22) were about overcharging and illegal charges for emergency and cancer patients, followed by misinformation about co-insurance (three). Patient complaint data was used to develop the interview frame for in-depth interviews, the second data collection method.

Semi-structured in-depth interviews were conducted face-to-face with 20 patients and patient relatives between December 2018 and January 2019. The interviews lasted an average of 40 minutes and were audio-recorded with the informants' consent and then transcribed verbatim. Informants were selected from patients or relatives who had used private services in the past three months. Informants were recruited through both purposeful and snowball sampling, both of which is extensively used in reaching difficult-to-locate participants (Guba and Lincoln, 1985). The purposeful sampling was employed to find informants who could potentially meet the inclusion criteria: reaching out to patients and patient relatives complaining about their recent experiences with PHOPS and referrals from informants of non-governmental organisations about people living with rare or complex health conditions. This strategy was supplemented with snowball sampling, where each informant was asked to provide the name of other potential informants. Ethical approval for this study (No: 2018/13) was granted by the Institutional Review Board of Boğaziçi University.

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The majority of informants (17 of 20) were patients and three were patient relatives. Interviews were conducted in four different provinces: twelve in Istanbul, four in a small town of the Balıkesir, three in Ankara and one in Kayseri. Thirteen informants were women, and seven were men. The sample also includes a balanced share of informants based on their main reason for presenting to the hospital: eleven presented to a hospital with chronic health conditions, and the remaining nine suffered from acute health conditions.

All complaints and interview transcriptions were translated into English and analysed accordingly. The names of all hospitals, physicians, and informants mentioned were anonymized. Open coding and thematic content analysis, carried out manually by the researcher, were used to interpret the textual and transcript data. Transcript data were coded at three stages. At the first stage, the coding was based on the events that involved encounters between informants and PHOPS and the nature of the overall experience of informants in each specific event. The second stage of coding categorized the variety of reasons that informants cited for submitting to PHOPS, including their medical conditions. The third stage of coding was applied to deviations from or manipulations of the regulations that resulted in either restriction or denial of patient entitlement.

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5. Findings

Patient experiences with PHOPS are diverse. While most informants who presented to PHOPS with non-emergency acute conditions often had problem-free experiences, most of those with emergency, chronic or rare and complex conditions and a number of informants with acute conditions had to make informal payments as a result of the hospital's decision to game the system. In one case, the informant reported that her mother was denied service by a PHOPS, possibly because of the hospital's concern about cost.

The analysis of negative patient experiences shows that patients sometimes face significant challenges when attempting to access their entitlements, which points to an erosion of publicness in a hybrid healthcare system. Information asymmetry between patients and PHOPS, manipulation strategies of private providers, and the lack of effective public regulation are major factors in SHI holders' inability to receive their entitlements and in the non-realization of publicness of the system. These factors are

even more salient in cases where the patient's need is urgent or where there is a complex medical condition and/or where scarce specialist services are required.

Patient interviews and complaints are analysed here under four major headings so as to present the diversity of patient experiences: (1) problem-free experiences, (2) unfulfilled high expectations, (3) informal payments (for non-emergency services, ER services, and specialist services for rare or complex conditions), and (4) denied service.

5.1. Problem-free experiences

The interviews revealed that the internal market required patients to gather information about the conditions for accessing treatment and choose their provider accordingly. One informant described how she chooses a provider:

Researcher: Do you try to obtain information about the examination fee for medical interventions before you go to a private hospital?
Informant: Yes, absolutely. I always call the hospital and ask about their price. Then I decide whether to go or not. For instance, I got information about the examination fee for an ophthalmologic examination at H Hospital. I found it too expensive, so I didn't go to that hospital. (Woman, ophthalmology, Istanbul)

Decision-making processes similar to the one outlined above were described by several other informants who had neither an emergency nor a rare or complex condition (e.g., Woman, gynaecology, Istanbul). A problem-free experience with the PHOPS was possible in this quote above because the informant was well-informed, had neither an emergency condition nor was she in need of scarce specialist medical service, and she had multiple provider options available for the same service in Istanbul.

However, this quote also indicates that the informant adopted a market logic. The informant's use of the word 'price' to refer to co-insurance also implies that she had adopted a market vocabulary in explaining decision-making in the informal market context. Despite the problem-free nature of this experience for the informant, the quote above also indicates that the informant had normalised having to pay for access, which is an expression of a norm of market settings rather than of social citizenship.

5.2. Unfulfilled high expectations

Patient experiences diverge from the above-mentioned narrative when there are expectations from PHOPS that do not match what is actually available under the current

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regulations, especially with respect to unfulfilled populist promises. Some patient complaints, for example, suggest a mismatch between the legal definition of emergency and the patient's understanding of the term. For example, one patient commented:

> Last month, I cut my hand in an unfortunate accident. I lost a lot of blood. I rushed to X Hospital, which is the nearest hospital to my house. As I was fighting for my life, an attendant told my partner to register at the pay desk, and they took money for the stitches. As far as I know, in this kind of case, private hospitals are not supposed to charge. (Patient complaint, April 6, 2018)

This quote demonstrates that a mismatch between patient expectations and services provided under the current regulations causes conflicts between patients and PHOPS on the ground. In this case, depending on the degree of severity, the patient's condition might not be categorized as an emergency according to a strict interpretation of the SSI's definition. The patient nevertheless expected to receive ER services free of charge at the point of service, possibly due to the populist political discourse that touted ER as free of charge (Posta, 2010), without qualifying this promise.

The mismatch is not limited to ER services. Another complaint further evidences high patient expectations based on political discourse:

> I paid an examination fee of 55 TL and a serum fee of 95 TL to X Hospital. After nine days, I went for a follow-up examination, and they conducted some tests. I paid 121 TL for those tests. I have SHI thanks to my employment, but they still took 271 TL from me. Why do we pay for this? SHI holders aren't supposed to pay any more when they go to a private hospital. I ended up paying with my debit card. I have the documents to prove it. (Patient complaint, March 16, 2018)

The above quote reveals that the patient is referring to the 2010 change that prohibits private hospitals from charging co-insurance for a specific set of services. However, this expectation does not correspond to actual regulations.

5.3. Making informal payments

5.3.1. For non-emergency services

While the 2003 healthcare reform was intended to establish a single-payer model in healthcare financing and to strengthen the publicness of the system, most interviews showed that patient experiences do not reflect this intended goal of the reform. Some providers reportedly treated informants as private patients and charged them market

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prices. One informant, for instance, reported that he applied to the cardiology department in a private hospital to undergo bypass surgery. He noted that he had no other choice but to present to the private hospital because it was the only hospital nearby with a cardiologist on staff. Similar stories about a lack of specialists in public hospitals that led informants to submit to private services were also reported in a few other interviews (e.g., Woman, oncology surgery, Kayseri). The informant who submitted to a private hospital to undergo bypass surgery explained his experience as follows:

Researcher: You didn't get an invoice?
Informant: None was given. I read something about it on a website later on. Certain surgeries, even if they are performed at a private hospital, are free of charge, and one of those is bypass surgery.
Researcher: Right, they are not supposed to take any fee for that.
Informant: But they charged us for it. (Man, cardiology, Balıkesir)

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In this case, the informant's lack of accurate information and the ability of the provider to register the informant as a private patient disempowered him vis-à-vis the PHOPS, which resulted in an unregistered payment for a free-of-charge service, and without any evidence of the billing. In another interview, an informant explained her experience of making an unregistered payment for labour and delivery services in the maternity department of a PHOPS that offers maternity services. She stated:

We had an acquaintance there, a physician. We told him (the physician) 'they charged us 3,300 liras for the delivery, could you help us on this?' He made a discount and reduced the fee to 3,000 liras. Then we asked for a detailed receipt from the hospital. The employees at the pay desk told us, 'X made a discount for you, so we can't give you a detailed invoice'. (Woman, gynaecology, Balıkesir)

As the quote suggests, due to her lack of information, the informant made an informal payment to the PHOPS for a service to which she was entitled free of charge. Her request for a receipt was refused because she had received an informal discount on the original price. The quote also exemplifies the recurring theme in other interviews (e.g., Paraplegic man #1, ER, Istanbul; Woman, cancer surgery, Kayseri) that reveal a strategy that PHOPS use to manipulate patients. In cases where patients have personal connections with physicians in a private hospital, PHOPS sometimes allow those physicians to charge a 'discounted' price. This strategy has a clear financial benefit to PHOPS, as the revenue is higher than treating these patients as SHI holders and

receiving the SSI reimbursement and co-insurance. As the quote above shows, if patients question the price or ask for a receipt, PHOPS use patients' personal connections with physicians and an informal discount as excuses for not issuing a receipt or allowing a challenge to the charge.

5.3.2 For ER services

While some informants had problem-free experience using their SHI in private ER services (e.g., Man, ER, Ankara; Woman, ER, Ankara), the complaint of a relative of a patient quoted below illustrates that if the patient is an emergency case, her vulnerability is often greater when the provider decides to manipulate the system.

> I took my father to X Hospital with chest pain complaints. We were directed to the internal medicine department. After the tests, we were informed that he had had a heart attack and we were sent immediately to the cardiology department. After the examination, we were again told that he had had a heart attack and that immediate intervention was required. When I asked about the price, I was told by the cashier's office that 500 TL would be charged for each stent. I accepted the fees because he was in an emergency situation. This private hospital charged a person who had had a heart attack. When we asked about this, they replied that we were charged because we had first applied to the internal medicine department. They said there would have been no charge if we had applied first to the ER. How could I know that my father had had a heart attack? (Patient complaint, May 3, 2018)

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This complaint, which is corroborated by several other interviews (e.g., Paraplegic man #2, ER, Istanbul; Man, ER, Istanbul), reveals three major obstacles to the provision of free ER services in private hospitals. First, some patients lack awareness of their entitlements. Second, PHOPS sometimes employ manipulative strategies to bypass the regulations, or game the system, to charge the patient at market prices. Third, given the perceived emergency of the medical situation, patients and their accompaniers generally accept all requests for payment from providers without questioning their legality. As the quote above indicates, they start to question the legality of the provider's behaviour only after the emergency ends, if they ever do so at all.

5.3.3. For specialist services for rare or complex conditions

A few interviews revealed that patients with rare or complex conditions are in a particularly vulnerable position vis-à-vis PHOPS, especially when a public provider option does not exist (e.g., Patient relative, a child with cystinosis, Ankara; Paraplegic

man #2, general surgery, Istanbul). One paraplegic informant, for instance, recounted his experience of applying to the urology department in a PHOPS for a clean intermittent catheterization (CIC) when his catheter started to fail. He reported that only a handful of urology specialists in Istanbul have the expertise to perform a CIC on a paraplegic patient, and they all work at private hospitals. Therefore, he applied to a PHOPS as an emergency patient. Under the legislation in force, he should not have paid any co-insurance. His experience was as follows:

Researcher: When you applied to that hospital, did you make a payment to top up your SHI?
Informant: I was desperate. No, my SHI was not valid there.
Researcher: Why not?
Informant: Do you know why? If they registered me through SHI, the extra fee they wanted to charge me would cause legal trouble for them because it is against the regulations of the SSI. For that reason, they registered me as a patient without any health insurance who is willing to pay for treatment out-of-pocket. (Paraplegic man #1, urology, Istanbul)

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The experience described above demonstrates that patients with rare or complex conditions sometimes feel that they are obligated to accept PHOPS manipulation strategies in order to secure future access to scarce specialist services. The informant added he thought that challenging the legality of the PHOPS behaviour would harm his relationship with the specialist from whom he receives vital services. To prevent this from happening, the informant agreed to pay OOP for the service and refrained from filing a complaint. This quote also shows that formal entitlements do not always lead to realised publicness. Ensuring access to vital services in the future can take primacy over claiming a legal entitlement—unless that legal entitlement is easily realised.

5.4. Denied service

It would be a contradiction in terms to argue that a PHOPS were to deny service to an SHI-holder patient unless it has a large space for manoeuvring in registering patients as either SHI-holders, PHI-holders or private patients. However, this generous leeway was granted to PHOPS, while exactly how these hospitals carry out internal rationing or ‘economic triage’ (as used in Henry et al., 1986) is unknown. From an economic point of view, patients who want to use their SHI entitlements might be placed in a disadvantageous position. In fact, one informant expressed his concern that his mother

might have been denied service by a PHOPS due to the cost concerns of the provider—because she was an SHI-holder rather than a private patient. He noted:

Intensive care might have lasted months for her. It lasted only five days, but it could have taken a lot longer. I guess they don't want these kinds of patients to stay at their hospital. … Later on, they called 112 for an ambulance *(similar to 911 in the U.S. or 999 in the U.K.)* to transport her to any other hospital where there was available space, since they told us that they did not have space … We asked if the situation was urgent, and they told us to 'take her to another hospital as fast as possible'. They scared us just to discourage us from demanding that she stay there. (Patient relative, intensive care, Istanbul)

It would be difficult to determine if the above-mentioned provider rightfully transferred the patient to another provider due to a lack of service capacity or if it was a covert way of restricting access by avoiding a patient who would potentially require a long stay in the intensive care unit at SSI rates. The informant's concern, nevertheless, points to the significance of internal rationing practices in private providers in hybrid healthcare systems. This concern also implies a low level of trust between patients and providers.

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6. Conclusion

The establishment of internal markets for publicly-funded healthcare service provision and thus the marketization of social services while keeping public financing intact has not always led to the erosion of publicness. Putting internal markets into practice while ensuring publicness necessitates effective public regulation to ensure that private providers act in accordance with public goals rather than pursuing their economic interests. The present study contributes to the emergent literature on the functioning of internal markets for healthcare and its influence on publicness. While the state's new role in healthcare has been examined from an institutional perspective (e.g., Helderman et al., 2012; Van de Ven et al., 2013), research on the actual functioning of internal markets and patient experiences has remained limited. Furthermore, the publicness of social services is generally studied in the light of quantitative indicators such as the share of the public sector in financing and provision. Although such research offers an important perspective, it provides only a limited picture of the issue at hand (Moulton, 2009). Through exploratory qualitative research on patient experiences, the present study investigated the influence of the internal market reform on the realised publicness of healthcare services in a new hybrid system. It treated information asymmetry and

informal payments as points of entry for examining the effects of internal markets on the publicness of the system.

The present study finds that patient experiences with PHOPS are heterogeneous, ranging from problem-free experiences to unfulfilled high expectations raised by populist discourses and demands for informal payments. The analysis of negative patient experiences with the internal market shows that patients sometimes face significant challenges in accessing their entitlements and offers evidence of the erosion of publicness in a hybrid healthcare system.

The present study also shows that the new system has amplified the information asymmetry between patients and providers. The information that patients must obtain and process in order to navigate the system successfully is complex and multi-layered. The analysis of interviews and online patient complaints reveals that this need for grasping and applying complex information on the part of the patients, coupled with the ability of PHOPS to game the system, and a lack of effective public regulation makes patients vulnerable vis-à-vis PHOPS, which operate under strong market accountability pressures. These factors are particularly critical in case of a patient's urgent need for treatment, a complex medical condition and/or a need for scarce specialist services. Under such circumstances, patients have full access to entitlements within the hybrid healthcare system, but only if they are well informed, if their expectations correspond to the modus operandi of the system, if they are not in an emergency and/or in need of scarce specialist medical services, and there are multiple providers -including a public sector option- of the service they need.

Although the internal market aimed at strengthening single-payer financing, the patient experiences analysed in this study paint a different picture. The analysis indicates that PHOPS, which operate under strong market accountability pressures and are reimbursed by the SSI at low rates, have a large space for manoeuvring in how they register patients—as SHI-holders, as PHI-holders or as private patients. This loophole allows them to evade public regulation and demand informal payments for services that patients are entitled to receive free of charge as SHI-holders. The informal payments mentioned in this study were mostly involuntary and in cash, and such payments were made for accessing standard services, which differ from gratitude payments and in-kind gifts made after the receipt of service.

This study sheds light on cases where patients are required to pay for services that they are entitled to receive free of charge and provides evidence of the erosion of

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the publicness of the system. The involuntary nature of the informal payments discussed here is characterized as 'the worst possible form of private financing' due to its negative implications for access (Gaal et al., 2006: 256).

In addition, in light of Taylor-Gooby's (1999) insights, such provider behaviours have undermined the framework of trust, which may have led to the undermining of social citizenship. The present study also finds that informal payments did not disappear with the reform but may have instead shifted from public providers to PHOPS. This phenomenon may explain, at least in part, the recent increase in the share of OOP payments in healthcare expenditures. Finally, the study points out informal payments in healthcare are not unique to public providers in developing and transition countries; they may be made as well to private providers in internal markets.

This study reveals that a policy trade-off exists between ensuring the realised publicness of healthcare services in an internal market and keeping public spending on healthcare low, especially when private providers are expected to offer publicly-funded services in a loosely regulated setting. While the presence of a strong public sector in healthcare provision is a sine qua non for the realisation of publicness, the internal market may serve public goals if effective public regulation is in place including the closure of existing loopholes for providers, enhanced reimbursement and simplification of patient access to entitlements.

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