THE ROLE OF THE EUROPEAN UNION ACCESSION PROCESS FOR THE RIGHT TO HEALTH IN TURKEY IN THE POST-REFORM PERIOD

A Master's Thesis

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Graduate School of Economics and Social Sciences
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I certify that I have read this thesis and have found that it is fully adequate, in scope and in quality, as a thesis for the degree of Master of Arts in International Relations.

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ABSTRACT

THE ROLE OF THE EUROPEAN UNION ACCESSION PROCESS FOR

THE RIGHT TO HEALTH IN TURKEY IN THE POST-REFORM PERIOD

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Since the initiation of the Health Transformation Programme in 2003 a series of reforms in health and social security systems have been realized in Turkey. An examination of the official documents related to these reforms in light of the international right to health documents reveals that the former is coherent with the latter, at least ostensibly. Considering the influence of the EU accession process on Turkey as a candidate country, especially in issues concerning human rights, one may expect to see a push from the EU in the issue of health, as well. However, an examination of the EU's demands in the accession documents concerning the health care system, reveals that EU does not have a strong human rights emphasis in health-related issues, especially before 2003. Interestingly, a right to health sensitivity in the accession documents begins to be observed after 2003, namely the

initiation of the Health Transformation Programme. This shows that right to health is not something the EU ignores, but it hesitates to put concrete demands concerning it, be it because of the principle of subsidiarity, or the second class position the Union attributes to economic and social rights vis-a-vis civil and political rights. Whatever the reason is, the question whether the EU accession process has a role in the right to health sensitivity of recent health reforms in Turkey, can be answered negatively based on the accession documents.

Key Words: Right to Health, Human Rights, European Union, Turkey, Health Transformation Programme

ÖZET

REFORM SONRASI SÜREÇTE TÜRKİYE'DE SAĞLIK HAKKI

ÜZERİNDE AVRUPA BİRLİĞİ KATILIM SÜRECİNİN ETKİSİ

Üstünes, Benal Nazlı

Yüksek Lisans, Uluslararası İlişkiler Bölümü

Tez Yöneticisi: Prof. Dr. Yüksel İnan

Haziran 2011

2003'ten bu yana devam etmekte olan Sağlıkta Dönüşüm Programı'na, ve bu kapsamda gerçekleştirilen reformlara dair resmi metinler ile devlet yayınları, uluslararası sağlık hakkı belgelerinde geçen temel kavram ve ilkeler ile dikkat çeken bir paralellik göstermektedir. Adaylık statüsü gereği AB ile yakın ilişkiler içinde olan Türkiye'nin, özellikle insan hakları ile ilgili olarak kuvvetli AB baskısına maruz kaldığı göz önüne alındığında, sağlık hakkı prensiplerine kağıt üzerinde de olsa gösterilen özenin arkasında da AB aranabilir. Oysa, katılım süreci belgeleri incelendiğinde görülmektedir ki, özellikle 2003'ten önceki dönemde, sağlıkla ilgili alanlarda kuvvetli bir insan hakları vurgusu yoktur. Sağlıkta Dönüşüm Programı'nın başladığı 2003 yılından itibaren ise, sözü edilen belgelerin sağlık ile ilgili alanlarında sağlığa bir hak olarak yaklaşım çok daha hissedilir hale

gelmeye başlamaktadır. Bu durum AB'nin aslında sağlık hakkına karşı bir umursamazlık içinde olmadığını, sağlık hakkını somut talepler haline getirmekten kaçınıyor olmasının ardında yerindenlik ilkesi ya da sosyal ve ekonomik hakların diğer insan haklarından farklı görülüyor olması gibi sebepler olabileceğini düşündürmektedir. Sebep her ne olursa olsun, katılım süreci belgeleri göz önüne alındığında, Türkiye'de son dönemde gerçekleşen sağlık reformlarında görülen sağlık hakkı hassasiyetinin ardında AB katılım sürecinin rolü var mı, sorusunun yanıtı olumsuzdur.

Anahtar Kelimeler: Sağlık Hakkı, İnsan Hakları, Avrupa Birliği, Türkiye, Sağlıkta Dönüşüm Programı

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ABBREVIATIONS and ACRONYMS

CAT……………….………………………………The Convention Against Torture
CEDAW……...The Convention on the Elimination of All Forms of Discrimination against Women
CERD…The Convention on the Elimination of All Forms of Racial Discrimination
CESCR……………………..…Committee on Economic, Social and Cultural Rights
CHP………………………..…Cumhuriyet Halk Partisi (People's Republican Party)
CoE……………………………………………………………….Council of Europe
CRC………………………………..……The Convention on the Rights of the Child
EC…………………………………...Treaty Establishing the European Community
ECHR……………………………………...European Convention of Human Rights
ECtHR……………………………………………European Court of Human Rights
ESR……………………………...………………..Economic and Social Rights
EU……………………………………………...……………...European Union
GDP…………………………………………………..…Gross Domestic Product
HTP……………………………………......Health Transformation Programme
ICCPR……………………..…International Covenant on Civil and Political Rights
ICESCR………....International Covenant on Economic, Social and Cultural Rights
IDP…...…………………………………………..Internally Displaced Persons
ILO…………………………...……………….International Labour Organization
IMF…………………..………………………………International Monetary Fund
NGO………………………………...……...Non-Governmental Organizations
OECD…………………Organization for Economic Co-operation and Development
RTH……………..……………………………………………..Right to Health
SSK………...…………......Sosyal Sigortalar Kurumu (Social Security Institute)
TEU……………..………………………………………Treaty on European Union
UDHR……………..………………………Universal Declaration of Human Rights
UHI…………………..…………………………………Universal Health Insurance
UN………...…………………………………………………………United Nations

CHAPTER I

INTRODUCTION

European Union (EU) accession is a process of adaptation and harmonization for every candidate country. They pass through a course of Europeanization with the impact of both the concrete criteria set by the EU *acquis* and the magnetic field of European values. Human rights have a special place in this process. It is one of the core values of the Union, and the primary legislation has emphasized the utmost importance of respect to human rights for the organization numerous times.

Turkey is a candidate state who has long been trying to be accepted to the club. Its longstanding relations with the European Union go back to 1959, when it applied for association to European Economic Community. 1963 Ankara Agreement that created this association between the parties, led to the customs union which has been completed in 1995. In April 1987 Turkey applied for full membership to the European Community based on the Treaty of Rome. However it had to wait for more than a decade until its candidacy status was recognized in Helsinki in 1999. Accession negotiations began on 3 October 2005 with the decision of the intergovernmental conference in Luxembourg. This has been possible only after Turkey is considered to fulfill the

Copenhagen political criteria to the adequate degree. However, it still needs to improve its congruity with these political criteria, which includes democracy, rule of law, human rights and protection of minorities. During the negotiation process, in addition to the political criteria, Turkey is required to fulfill the economic criteria and complete the harmonization with the EU *acquis*.

The accession process is the strongest motive behind human rights developments in Turkey. It has made contributions to the human rights record of Turkey, which are operationalized in the harmonization packages. After numerous harmonization packages and constitutional amendments, although far from being adequate, there have certainly been developments in the areas of torture, right to property, freedom of association, freedom of expression and to some extent cultural rights. Knowing this, one may expect direct EU affect behind developments in the right to health, similar to these other examples. This paper will concentrate on the right to health as part of the human rights dimension of the accession criteria. It will try to evaluate the impact of the EU accession process on the situation of right to health in the Turkish health system.

The research question that this study will try to answer is "what is the role of the EU accession process for the right to health in Turkey in the post-reform period?" For the purposes of this study, the interactions between the EU and Turkey in the accession process will be examined through the accession documents. Although it is accepted that the accession process has many other direct and indirect mechanisms which bring about harmonization with the

European legislation and values, this study limits the scope of the search for right to health with the accession documents.

What is meant by the accession documents are the Accession Partnership Documents and the Regular Progress Reports. Other accession documents, namely the Negotiating Framework, and the National Programmes will be opted out as they do not directly involve the requirements for Turkey's accession as put forth and assessed by the EU. Right to health in Turkey will be evaluated according to the existing legal framework, and the situation in the field, such as the health status of people and the level of their enjoyment of right to health in getting healthcare. The main source that this thesis utilizes for the definition, requirements, and indicators of right to health is the General Comment No. 14 on the right to the highest attainable standard of health, by the Committee on Economic, Social and Cultural Rights (CESCR). The reforms that are mentioned in the question refer to health and social security system reforms that have been ongoing since 2003 in accordance with the Health Transformation Programme (HTP). What is to be examined in this study, will be the right to health elements in the reforms, and the existing and prospective right to health situation of the Turkish health system after the initiation of the reforms. Then, looking at the action-reaction relationship between the right to health demands of the EU in the accession documents and the right to health winds that blow in Turkey, the study will try to answer if EU pressure in the accession documents is the reason behind these winds.

Health is a legally recognized human right for the EU. Hence one may rightfully expect to see an attachment to this right, which is to be concretized in the accession process in the form of requirements, demands and criticism from the Union. It is a fact that many of the elements and principles of the right to health do exist in the official documents of the health and social security reforms of Turkey ongoing since 2003. Considering the importance of human rights in the EU accession process, also the impact of EU on human rights developments in Turkey, it would not be irrational to expect to see the influence of the accession process behind the ostensible right to health sensitivity of the HTP. However, scrutiny of the EU accession documents of Turkey showed that there is not a strong push from the EU for the enhancement of the right to health in the period leading to the health and social security reforms. Hence the shorthand answer to the research question is that based on the accession documents, one cannot talk about the role of the EU accession process behind the right to health developments in Turkey. However it is worth noting that this does not mean that there is no influence of the accession process on the right to health in Turkey at all. There certainly are other more indirect and subtle mechanisms in this process. However, the scope of this study is limited to the accession documents.

In order to answer the research question, in the following chapter, right to health will be defined in the framework of its historical development. Its basic elements will be explained as determined by the CESCR and almost universally accepted. State obligations on the right to health will be given. Later in the relevant chapter, Turkey's evaluation in terms of its respect to RTH will be

made based on these obligations. Finally at the end of the second chapter the value-added of the right-based approach to health will be given in order to show that the search for right to health in health systems is not a meaningless effort.

In the third chapter, the attitude of the EU towards right to health will be analyzed. Primary and secondary legislation will be skimmed through to understand both the place of the right to health among other human rights, and the importance of it in Union health policies. 2007 White Paper setting the European Health Strategy, and Second Programme of Community Action in the Field of Health will be examined. It will be seen that the recognition of the right to health does not turn into a commitment to oversee the right to health of the people living in member states.

In the following chapter, Turkey will be in the spotlight. First, a general socio-economic portrait of Turkey will be drawn. Then, an examination will be hold to see the situation of health and right to health in laws and practice. HTP will be scrutinized for an evaluation with respect to right to health. Finally, Turkey's overall performance in right to health since the initiation of the reforms will be tried to be assessed based on General Comment No. 14 on right to health, and the indicators in the study by Backman *et al*. It will be revealed that although the system is not explicitly defined as right-based anywhere, the right to health sensitivity can be observed in the documents of the reforms. However, this sensitivity on paper does not turn into practical realities of right holders' lives.

The fifth chapter will seek health and right to health in the accession documents trying to see EU pressure concerning the enhancement of the right to health situation in Turkey. EU's attitude towards the health-related developments in Turkey and the importance the Union attaches to right to health in making its evaluations will be examined. Contrary to what is expected, no concrete EU push for right to health will be seen in the pre-reform period. This will show that one cannot talk about the direct impact of the accession process (as reflected on the accession documents) on the ostensible right to health sensitivity in post-2003 Turkey. However, it may well be argued that the fact that this sensitivity is only on the paper may be a consequence of EU's disinterest in right to health. It is also interesting to see a gradual change in the position of the right to health in accession documents after 2003, the year HTP is initiated. After this date, health and human rights become integral parts of each other in the regular progress reports, although they were entirely unconnected before. This situation makes one think that apparently not the right to health stress in the accession documents brought about a right to health sensitivity to Turkish reforms, but on the contrary, right to health elements in the reforms made EU mention right to health more, be it as praises or demands.

CHAPTER II

RIGHT TO HEALTH

2.1 Economic and Social Rights

Health is a human right in the group of economic and social rights (ESR), hence for a comprehensive understanding of right to health, the framework of ESR should be understood. Although the underlying reasons and legitimacy of the distinction between civil and political rights (CPR) and ESR is an issue of debate, the practical reality at hand is that there are two separate covenants to deal with human rights in international law; 1966 International Covenant on Civil and Political Rights, and 1966 International Covenant on Economic, Social and Cultural Rights. The history of ESR is shorter than CPR. However, the idea of these rights is argued to be going back to late medieval Christian thought. (Freeman 2003: 39) The main role in the development of ESR as human rights however belongs to the working class struggles of 1830s and socialist movements of the 19th century. (Freeman 2003: 30) This role is performed by ILO in 20th century until the Second World War. Post-war period, along with the devastations of the great depression demonstrated the need for social protection and prepared the ground for Article 55 of the UN

Charter[1], and a comprehensive declaration of human rights three years later. (Alston, Steiner, Goodman 2008: 270-71) At the point of turning this soft law document into binding international law, differing views did not let the creation of a single covenant on human rights. This is problematic, because although "in principle the two covenants were said to be equal, in practice they were not. ICCPR was given primacy over ICESCR in the sense that it was complemented by an optional protocol and nascent institutional framework that would foster its growth and evolution. ICESCR (…) was left to (…) inchoate activities of specialized agencies and other *ad hoc* processes." (Williams 1998: 2) For some (Sepulveda 2003: 115; WHO 25Q&A), this discrimination is attributed to Cold War, and the "existence of a socialist block" standing as a rival to capitalist west. For others, having two covenants, with different provisions, is about the nature of the rights, rather than just cold war political climate. Basically, ESR are thought to be relative, cost-dependent, non-justiciable rights creating vague, positive obligations while CPR are absolute, cheap, justiciable and create clear, negative obligations. In this sense ESR can only be treated as programmatic objectives, with a degree of voluntariness for the states. (Williams 1998: 3) Based on these alleged differences, comes further debates about the place of ESR within human rights. Antagonists of ESR, like Cranston, argue that as their realization is impossible for some governments and as there cannot be a duty to do the impossible, there can be no right to them. (Freeman 2003: 71)

[1] Article 55: With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote: a) higher standards of living, full employment, and conditions of economic and social progress and development; b) solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and c) universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Cranston believes, thus, that “they are not truly human rights.”(Donnelly 2003: 28) However, the answer to all of these views, and wrong assumptions about the nature of ESR and their obligations is given by the CESCR in its General Comment 3, on the nature of state obligations.

As this tendency to give an upper hand to CPR has always been quite obvious, principles of indivisibility and interdependence have been emphasized by the UN in many occasions, most concretely in the Article 5 of the Vienna Declaration and Programme of Action, 1993. It states that “All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis.” (UN, 1993) 2006 document of “Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation” of United Nations Office of the High Commissioner for Human Rights (UNHCHR) stresses the interdependence of human rights and says that it is difficult, even impossible to realize rights in isolation from the others, as all rights are interdependent to each other. So a hierarchy of rights is unthinkable (UN, 2006). Although a large majority of human rights literature is constructed on these principles of indivisibility and interdependence, (Bauer, 2003; Shue, 1996) and has a holistic approach to human rights, this does not prevent a very strong tendency, especially in the west, of mentioning primarily CPR when they are talking about human rights. Prioritization, which is another important debate on this issue, is worth touching upon in this respect. Despite the principle of indivisibility, the question of prioritizing rights has always been an issue, first between east and

west, then between north and south. At the one extreme of the spectrum Lee Kuan Yew argues CPR hinder economic and social development in poor countries, so ESR must be given priority over them. (Sen 1999) At the opposite side of the spectrum stands the abovementioned rejection of ESR as true human rights that states are obliged to realize. The position of US, as seen in this official statement, is the clearest example to this: "Realization of *economic, social and cultural rights* is progressive and aspirational. We do not view them as entitlements that require correlated legal duties and obligations."[2] (Marks 2003: 147) Apart from these extremes, examples can be found in the idea of basic rights by Henry Shue (1996), in Amartya Sen's (1999) idea of the role of CPR for the achievement of ESR, or Thomas Pogge's (2002: 63) emphasis on the role of the "education system and economic distribution" for continuing respect for human rights.

On the list of human rights, health holds a very important position as a social right. In the next part the meaning and content of the right to health will be examined through basic international documents that comprise the right to health. Then, merits of handling health as a human right, rather then a public or economic good will be evaluated.

2.2 Right to Health

Right to Health, despite its direct relation with all other rights, primarily with the right to life, suffers from the same tendency of downgrading ESR. Health has begun to be considered as a human right for the first time with the

[2] Quoted from the statement of the United States Government at the UN Commission on Human Rights in 2003

constitution of the World Health Organization (1946) which states in its preamble that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” Since then it is being protected at international, regional and national levels. Two years after the adoption of the WHO Constitution, in 1948 the Universal Declaration of Human Rights has accepted a right to health. Inspired by the WHO constitution the ICESCR (1966) provided a comprehensive and influential provision on the right to health in its Article 12; “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” (Leary 1994) Apart from the Bill of Rights, health as a human right is also referred in other international and regional instruments such as the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, European Social Charter, African Charter of Human and People’s Rights and the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. There are also numerous states that have constitutionalized the right to health. Over 100 constitutional provisions make reference to health-related rights. (Hunt 2006)

Right to health, when thought along the dictionary meanings of the words, does not make much sense. No one can claim a right to be healthy all the time, or can talk about a right violation when he gets ill because of unavoidable reasons. However as a concept in international human rights law, right to health has a

predefined content which has been built upon a particular definition of health. Definition of health might be different for a medical doctor, for a medical ethics scholar, or for a public health worker. A narrow definition of health, for instance, which may be practical for a doctor, is the "freedom from clinically ascertainable diseases." (Montgomery 1992: 186) The definition that the WHO adopts and international human rights documents more or less embrace[3] is a much broader one. As stated in the constitution of WHO (1946, Preamble), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This is a "holistic" (Hellsten 2005: 149) approach which looks at health with its natural and social relations. For example while "the environmental concerns, conditions which make the spread of disease more likely and people more vulnerable to stress *are not directly relevant for the narrow understanding of health; but as* strong correlations can be shown between poor health and poverty, poor housing and lower socio-economic class, these are health issues *for the holistic definition.*"(Montgomery 1992: 186-187) Moving from this definition, the right to health gains a more reasonable and broad content, which cannot be limited to access to health care services in times of disease. Thus, right to health is more like a "shorthand expression" to refer to the detailed provisions in international law. (Toebes 1999: 663; Leary 1994: 26) For example the related provision in the ICESCR (Art. 12/1) use the wording of "highest attainable standard of physical and mental health", CRC (Art. 24/1) "highest attainable standard of health", and

[3] General Comment No. 14 says that in drafting the article, definition of the WHO Constitution had not been adopted. They do not give a definition of their own, either. However, the way the CESCR operationalize the right to health shows that their definition is similar to the one of WHO, and absolutely different from the narrow definition.

CERD (Art. 5/iv) "right to public health, medical care, social security and social services".

The most detailed and well-explained provision with regards to right to health is the ICESCR Article 12, which states that:

> "1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
> a.The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> b.The improvement of all aspects of environmental and industrial hygiene;
> c.The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> d.The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Today 160 states of the world are party to this covenant, thus accept the right to health as it is defined in article 12, and explained in the relevant general comment of the Committee.[4] Not only because the ICESCR is part of the core international human rights legislation, but also because of this wide acceptance, these documents may confidently be taken as a guideline in understanding, evaluating and implementing the right to health. This general comment, namely the General Comment No. 14 on the Right to the Highest Attainable Standard of Health, clarifies the provision by providing necessary explanations on the normative content and application of the right, on the obligations of state parties and of other actors, possible violations, and clues for national level implementation. By doing this, it removes the basis of many criticisms with regards to the vagueness of the right to a significant extent.[5] Although it does

[4] Although some countries put reservations on certain rights when they are being party to the covenant, there is no such reservation for article 12 by any country.

[5] However there still is some shortcomings, such as the absence of a clear cut definition of health, or as J. P. Ruger puts, lack of adequate elaboration on "the highest attainable standards in a world of diverse individuals with variable genetic and biological capacity." Ruger, J.P. "Toward a Theory of

not give a clear cut definition of health, it makes a clear connection between healthy life and dignity. (CESCR 2000, Paragraph 1) As a result of this, highest attainable standard of physical and mental health goes far beyond the right to "timely and appropriate healthcare" (CESCR 2000, Paragraph 11) and includes other factors that are required for a healthy life in this aforementioned sense of the term. These other factors are explicitly listed in the general comment as "a wide range of socio-economic factors (…) and underlying determinants of health such as food, nutrition, housing, access to safe and potable water, and adequate sanitation, safe and health working conditions, a healthy environment" and access to health-related information. (CESCR 2000, Paragraph 4) As can be easily understood, right to health is much more than doctors and hospitals, and its full realization necessitates respect for the rights to food, housing, clean environment among others.

2.2.1 Elements of the Right to Health

Right to health, from the perspective of the right holder has two dimensions; freedoms and entitlements. According to this, everyone has the freedom to control his/her body, and the right to be free from interference as in the cases of torture or involuntary treatments. As to the entitlements, everyone has a right to an equitable health system which ensures the highest attainable level of health to everyone, although it is accepted that "this level is dependant on both individual's biological and socio-economic factors, and state's resources." (CESCR 2000, paragraphs 8-9) As does the other rights in the covenant, right to health has certain elements that need to be satisfied for the full realization of

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a Right to Health: Capability and Incompletely Theorized Arguments" *Yale Journal of Law and the Humanities,* Vol. 18, 2006, p. 313

the right for everyone. By the Committee these elements for the right to health are listed as availability, accessibility, acceptability and quality.

Availability

Health care facilities, like hospitals or other medical clinics, health-related goods, equipments, medicines and services must be sufficient and available. Existence of appropriate programmes to maintain all these is also necessary. Besides such direct requirements, availability of sufficient nutrition, clean water, adequate housing for everyone is also included in this heading, as they are considered by the Committee as the underlying determinants of health and indispensable for a healthy life.

Accessibility

Existence of neither health care facilities, nor health protection programmes, or plenty of potable water do not mean much for the people when they are unable to reach them. There might be different reasons of their inaccessibility. If such facilities, services or goods cannot be used or achieved by a group of people within the country, be it caused by a discriminatory legislation, or practice; or by the lack of an interpreter which renders a certain service impossible to use for a language minority group, this would be discrimination and it is a violation of human rights. Visible or invisible discrimination is a core reason behind poor health status. (WHO 2002: 11) Hence non-discrimination is the first condition for the full enjoyment of the right to health by everyone.

A second condition is physical accessibility. Very clearly hospitals in urban areas are not easily accessible for rural inhabitants; or clinics with high steps at the entrance cannot be deemed accessible for the disabled people. Health facilities, goods and services, including the ones related to the underlying determinants of health "must be within safe physical reach for all sections of the population." (CESCR 2000, Paragraph 12)

A third condition is for these goods and services to be economically accessible for everyone, including for example the socio-economically most disadvantaged. No one should be deprived of treatment for his disease just because he cannot pay for it. The Committee does not impose a certain healthcare or social protection system, but it requires states to ensure the affordability of health services by everyone whether they are publicly or privately provided. (CESCR 2000, Paragraph 12) The concept of equity is very important in this issue of affordability, as whatever the state's system for financing health care is, the distribution of the burden should not be disproportionate with regards to socio-economic levels.

The forth and the last dimension of accessibility condition is information accessibility. Within the limits of confidentiality due to the secrecy of private life, health-related information and ideas must be open to reach of everyone. Everyone should have the right to search for, reach, and use them.

Acceptability

Facilities, services, treatments, and goods must all be respectful to cultural sensitivities of different communities such as the indigenous peoples or minorities. Otherwise, the attitude would carry the risk to be both discriminatory and disrespectful to privacy and cultural rights.

Quality

Professional education and skills of medical personnel, quality of the facilities, and the technical equipment, effectiveness and safety of the drugs, safety and quality of potable water, etc. must be at an acceptable level, scientifically and medically appropriate, and although not stated in the general comment in this way, must be as close to the best example in other places of the world as possible.

2.2.2 State Obligations on the Right to Health

From the perspective of the duty-bearer, namely the states, the biggest concern should be its obligations with regard to the right to health. A crucial point on the nature of state parties' obligations towards social and economic rights is that as it is stated in Article 2/1 of the ICESCR (1966), states undertake to take steps to progressively achieve the full realization of the rights, utilizing the maximum of their available resources. As Paul Hunt, former Special Rapporteur on the right to health very simply puts it, "progressive realization means that states are expected to do better next year than they are doing today, while resource availability acknowledges that what is required of a rich country is of a higher standard than what is required of a low or middle income

country.” (Hunt 2007) Still, once again as established in General Comment No. 3 on the Nature of State Obligations and reiterated for the right to health in General Comment No. 14, states also have some obligations of immediate effect, which cannot be subject to progressive realization, or excuse of resource availability. These are non-discrimination and the obligation to take deliberate, concrete and targeted steps. (CESCR 2000, Paragraph 30)

Apart from these, states has obligations *vis a vis* human rights in general, and right to health in particular in three levels. These are the obligation to respect, protect and fulfil. Without going into details, obligation to respect in right to health, according to the general comment comprises of the negative obligations of the state such as abstaining from all sorts of discriminatory policies and practices in the area of health, abstaining from hindering the ways people are enjoying their right to health, refraining from any sorts of actions that can cause a deterioration of people’ health, such as polluting the environment. Obligation to protect points to the responsibility of the state to prevent third parties from damaging people’s health, or impeding their full enjoyment of the right to health through any means. Controlling the facilities and services provided by the third parties with regard to their appropriateness to the standards and conditions of the right to health, and ensuring this with necessary legislations and mechanisms. The obligation to fulfil includes the positive obligations of the states, such as taking actions to set the necessary conditions and create the necessary environment for the full realization of the right to health. There is a very long list of obligations of this sort varying from preparing an appropriate human rights-sensitive national health strategy, to building the infrastructure to

ensure easy access of everyone to water; or from building hospitals and training medical personnel, to taking the necessary steps to prevent occupational diseases. State parties' obligations with regard to right to health will tried to be examined in more detail as they are listed in the general comment, in the next chapters when evaluating the fulfilment of Turkey of its duties in right to health.

The last section of the general comment on the right to health which is worth touching upon at this point is the guidelines it provides about the implementation at the national level. Notwithstanding the recognition of the margin of discretion of every state in deciding their policies and programmes with regards to the fulfilment of the right to health, the Committee states that a national health care and health protection strategy based on human rights principles is a must for taking "deliberate, concrete and targeted" steps for the full realization of the right. (CESCR 2000, Paragraph 30) This national health strategy, according to the Committee must respect the principles of non-discrimination, people's participation at every stage beginning from policy designs, transparency, accountability and effective remedies for violations. There must be a certain system of monitoring in order to be able to evaluate the progressive improvement towards a full realization of the right. Thus identifying indicators, setting benchmarks and regularly collecting disaggregated data are also requisites of a human rights-based health system. (CESCR 2000, Paragraphs 53-62)

2.2.3 Human Rights-Based Approach to Health: What is the Value-Added?

Rights-based approaches in general are gaining increasing influence and importance parallel to the strengthening of human rights. Its merits have been examined by many scholars especially after 1990s. Taking the issue of health in a human rights framework brings the merits of a rights-based approach into the health arena. Rights-based approach takes empowerment as the primary goal. Empowerment of the duty-bearer through increasing its capacity to fulfill its obligations, and empowerment of the right-holders in claiming their health rights lie at the heart of the right-based approach to health. (WHO n.d.) As compared to other approaches to health like the very common public health approach, this is a fundamental change. Public health approach is a problem-oriented one. It defines its goal as decreasing the health problems in the population. As the method, it concentrates on a problem looking at its importance for the population as a whole, and then tries to solve that particular problem with interventions directing the immediate causes of it. Although this may work for the elimination of the impacts of that particular problem, the underlying factors, especially the structure that they are socially produced and reproduced would be untouched. (Filho 2008: 97)

The concept of human dignity which is well associated with human rights as expressed in the UDHR preamble enters to health policies and practices as a major concern with the rights-based approach. (Leary 1994: 36; WHO 2002) With the understanding of health as a human right, respecting and protecting the inherent dignity of the human person becomes a central issue in health care

practices and all other health-related services and policies. (Leary 1994: 37) Other approaches like the public health approach rotate mainly around utilitarian understandings looking at averages. The major concern for the public health approach is the collective health status of the population as a whole. (WHO 2008: 2) Human rights, on the other hand, emphasize the values of the individual human beings as opposed to an understanding prioritizing community health in any case even if it is at the expense of individuals. Human rights law explicitly recognizes the legitimate circumstances where restricting human rights for public health can be accepted. Among them, according to 1984 Siracusa Principles,[6] there are requirements to be prescribed by law, to be the least restrictive measure, not to be arbitrary or discriminatory, etc. Limiting the limitations of rights is an important gain of human rights-based approaches. Elaborating on Dworkin's idea of "rights as trumps", Leary argues that using the language of rights in health gives health an upper hand compared to other goods, and "underscores health as a social good and not solely a medical, technical or economic problem." (Leary 1994: 36)

The framework human rights sets to approach health-related problems, including the national and global ones gives prominence to "social and ethical aspects of health care and health status." (Leary 1994: 35) Doing this, new concerns such as the humanitarian appropriateness of methods and consequences of actions, penetrate into health issues breaking the dominance of technical, disease-oriented approaches. (Hunt and Backman 2008: 83) This is

[6] The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights is the document of UN Commission of Human Rights, dated 28 September 1984, which lists and explains the legitimate and acceptable circumstances that human rights can be limited.

both the reason and the outcome of the extended understanding of health with underlying social factors that a rights-based approach provides. Health cannot be seen as a commodity or a market good in such a framework, but has to be conceived as a fundamental right that should be recognized and provided to everyone regardless of the cost-benefit calculations. (Leary 1994: 37)

Besides the new understanding, handling the issue of health in the human rights framework opens the guidelines prescribed by human rights documents to the use of health policy makers and health practitioners and brings about new norms. (Hunt and Backman 2008; London 2008) The requirement to attribute importance to the processes as much as outcomes is one of these. It is unacceptable in a human rights-sensitive practice to disregard human rights norms in the path to achieve an objective, even if that objective is a perfectly benevolent one aiming to enhance human rights. Principle of progressive realization with the maximum of available resources defined in human rights law have the potential to serve as a torch to guide the states in the right direction when they are dealing with health under pressure of resource constraints. Similarly the core obligations, which are obligatory to fulfill immediately also come from human rights law. Other norms that the human rights-based approach brings about include, but not limited to, quality, transparency, accountability, participation, non-discrimination, equity, and equality. Non-discrimination is one of the most prominent and significant point in this expandable list. Not only avoiding discriminatory policies and practices, but also controlling and preventing unintentional discriminatory consequences is a must in rights-based approach to health. So with a human rights

perspective, a policy maker cannot be doing his job properly as long as every national, ethnic, religious, gender, age, social-economic group does not benefit from health policies and services equally, without encountering any sort of intentional or unintentional discrimination. Any such case would be a violation. For example, respect for cultural differences (Hunt and Backman 2008: 83) and preferences in provision of health care is a requisite for non-discrimination, as health services should be acceptable for everyone. Ignorance of this factor in policy making, or practice might not at first sight seem as discrimination, but if a cultural group cannot enjoy a service equally with the rest of the population, this means their right to health is being violated.

Vulnerable groups of the societies are particularly important in this sense. Ensuring that women, children, disabled people, immigrants, minorities or indigenous people and their peculiar needs and problems are not ignored in planning and providing health-related services is a point that the human rights law emphasizes over and over again in many documents. Empowering the disadvantaged groups and individuals is an obligation of the states. (Hunt and Backman 2008: 83) It is quite common to witness worse health statuses in women compared to men, in minorities of a population compared to the majority, in low socio-economic levels compared to better-off segments; and it is a violation of human rights in part of the states if they do not take all the necessary measures in law and in practice, to prevent these by giving special attention to disadvantaged groups. (Leary 1994: 38) Protection of the individuals' rights or of such disadvantaged groups from the repressive needs

of the larger populations outside the limitations prescribed by law is indispensable in rights-based approaches unlike others.

To maintain such a protection of disadvantaged or vulnerable groups they should be empowered. Empowerment according to human rights law would be possible by giving voice to them, for which the best way is to ensure their participation in health-related issues at all levels. All phases of decision making in health-related matters should be open to "free, meaningful, and effective participation of beneficiaries of *the* policies or programmes" (WHO 2002: 17) not leaving any group aside. Although such issues might be highly technical in nature, it is state's duty to ensure a bottom-up, rather then a top-down system in health strategy setting, policy making, and implementation as they should be sensitive to both national and local priorities. (Hunt and Backman 2008: 82-83) A strong civil society, health-related NGOs like professional associations are important requirements of a meaningful participation, hence their existence and power against governments is a *sine qua non* in a human rights-sensitive health system. On the issue of participation, Leslie London stresses the concept of agency. (London 2008: 66) He argues that rights-based approach to health changes the perception that sees people as "passive recipients of assistance" which states benevolently help. (London 2008: 68) This is fundamentally different from the public health approach or the need-based approaches. Rights-based approach perceives the right holder as active agents with choices and capabilities and aims to strengthen this agency through giving them more voice and influence.

Monitoring the practices and their consequences; collecting disaggregated data showing the status of women, children, different socio-economic segments, and so on; evaluating these according to human rights standards; and ensuring free access to health-related information for everyone are other crucial aspects of a right-based approach to health which make big contributions both to human rights and health in a country. Transparency is an important human rights norm here, which is required for an appropriate application of these.

Human rights are legal norms with quite a well-established legal background in international law. When a human-rights based approach to health is embraced, this brings forth the legalization of many norms, principles and concrete obligations. So protecting the health of the individuals and communities as defined and explained in human rights documents become a legal issue beyond ethical responsibilities for the states. Rights are entitlements, thus once health is accepted as a human right with international guarantee, each individual gains a "legal and political legitimacy to the claims for its enjoyment."[7] Entitlements of the right-holders automatically bring about the obligations, thus accountability of the duty-bearers. Bad policies, weak implementations, inadequate attention to human rights implications become legal issues, and responsibles becomes accountable for their failure or ignorance. A state should provide means, be them legal, paralegal or political, for its people to claim their rights and seek redress in case of violations. (Leary 1994: 39) Human rights language not only brings about the legal power, but also the power and support of the civil

[7] Hernan L. Fuenzalida-Puelma and Susan Scholle Connor eds. 1989. *The Right to Health in the Americas.* Pan-American Health Organization. Scientific Publication No. 509. Washington, p. 10 quoted in Leary, Virginia. 1994. "The Right to Health in International Human Rights Law" *Health and Human Rights.* Vol.1/1
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society, as human rights has a strong civil society support behind it. (London 2008) The means and methods that the human rights community utilizes like public recognition, naming and shaming, petitions become non-legal tools that can be used to fight against right to health violations.

CHAPTER III

EUROPEAN UNION AND THE RIGHT TO HEALTH

3.1 Economic and Social Rights and the European Union

EU's position on the issue of CPR-ESR divide is an explicit adherence to the principle of indivisibility. (Council of the EU and European Commission 2007; Alston and Weiler 1999) However, a deeper look to the human rights in the Union to evaluate the real weight of ESR, gives signs of a prioritization of CPR and minority rights.

Founding treaties of the Union does not say much on human rights apart from brief general statements. 1957 Treaty of Rome has no reference to fundamental rights, except a clause on non-discrimination. The most important and basic provision on fundamental rights in EU treaties is the Article 6 of the 1992 Treaty on the European Union (TEU) which states that human rights is a founding value of the Union. The same article in the second paragraph states that the Union respects fundamental rights as guaranteed by the 1950 ECHR and common constitutional traditions of member states. The critical aspect here is the fact that ECHR is a Council of Europe (CoE) document which is composed of only CPR without any social or economic right. Referring only to

ECHR leaves ESR untouched. For the social rights side, EU has the 1989 Community Charter on Fundamental Social Rights of Workers. However, this is not a binding document. Moreover, although it protects certain social rights, the impression is that the charter was neither created nor intended to be used as a human rights document, aiming to guarantee all ESR to every human being. Instead, its primary aim is to constitute the “social dimension of the single market” (Europa 2005) trying to ensure smooth functioning of the single market rather than serving as a basis for ESR in general. When the TEU was signed in 1992, ECHR was not the only human rights document of the CoE. The “natural complement” (“The European Social Charter”) of this convention; the European Social Charter which was signed in 1961 and revised in 1996 was also there with its ESR content. Keeping this in mind, making reference only to ECHR and ignoring the European Social Charter was clearly a choice for the EU, of associating human rights with CPR only. This situation continued until 1997 Amsterdam Treaty. Amsterdam Treaty incorporated both the European Social Charter and 1989 Community Charter of Fundamental Social Rights of Workers into the acquis with the amendment in TEU. With this, ESR, as well, are embraced in the treaties. However, even after Amsterdam, the equality of the statuses of two sets is still questionable. (Giubboni 2003) Until the European Charter of Fundamental Rights, which is the first attempt to crystallize all fundamental rights in the EU structure, the European Court of Justice case law constituted the way human rights were upheld in the EU system. As the Court is based on the ECHR solely, the development of human rights in EU has been within the aforementioned CPR-dominated framework. The importance of and support to CPR in liberal democratic traditions of

Western Europe has also contributed to the development of CPR within this system (Forsyth 2000: 123), while leaving ESR weaker. The Charter of Fundamental Rights, which is now binding since the coming into force of the Lisbon Treaty, came out of the idea that rights should be more visible to people than they are in an indirect protection system. It is constructed with the principle of indivisibility, listing and protecting ESR as well as CPR. Scrutiny of the document shows that it includes all the rights in the European Social Charter such as the rights to housing, education, employment, social protection, movement of persons, non-discrimination although generally in a more brief fashion. However, "the rhetorical commitment *to economic and social rights* has hardly been matched by practice." (Alston and Weiler 1999: 31) The balance between two sets of rights in the Charter is not really reflected in every policy and legislation of the Union.

The first place that anyone would consult to find answers to EU related questions is Europa, (www.europa.eu) the portal site of the EU which provides information on almost every aspect of the Union. A careful eye, may notice the imbalance between CPR and ESR in the Human Rights page of Europa. Most visibly, the list of links for 'Human rights outside the European Union' under the title of 'Legislation' includes no economic and social right apart from children's rights. (Europa 2011a) What we look for, namely an evident concern for ESR to balance the emphasis on CPR could have been found in development policies of the Union. Although human rights is more and more taking its place as the general language of development and poverty eradication

in the world, EU does not seem to be following this trend. In the summary[8] of the development activities in Europa page, where the development policy of the Union is explained, “human rights” is used only once. EU declares that poverty eradication is the primary and overarching objective of EU development policy, but the lack of a rights-based approach to poverty eradication can still be felt (Europa 2011b). EU and its member states constitute the biggest aid donor in the world. Taking MDGs as a guideline in operationalizing this aid is a sign of the right intentions of the Union regarding elimination of basic problems world poor face. However, despite this commitment to help developing countries solve health, education, food related problems; right to health, right to education, right to food are never mentioned. All these contribute to the conviction that ESR are given an inferior position, as rights language is not used for this group as it is used for CPR.

3.2 Health and the Right to Health in the EU

In the EU, health is considered as an area that is supposed to be under the full responsibility of states. According to the principle of subsidiarity, as defined in Article 5 of the Treaty on European Union[9], all the actions and decisions should be taken at the state level as long as it is possible to do so effectively. The core of the principle is to keep decision making and implementation at a level closest to the citizen. Health is an issue that falls under the principle of subsidiarity. As will be explained in this section, EU does not intervene in the

[8] 666 words long

[9] Treaty on European Union, as consolidated in Lisbon Treaty states in its article 5 that: “Under the principle of subsidiarity, in areas which do not fall within its exclusive competence, the Union shall act only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States, either at central level or at regional and local level, but can rather, by reason of the scale or effects of the proposed action, be better achieved at Union level.”

design, organization or implementation of health systems of the member states; but deals only with international or cross border aspects of health. Another important point for this study is that although Union recognizes its citizens' right to health in various documents, it does not make direct references to neither the concept, nor the term of the human right to health. The aim of health-related policies and programmes is to enhance public health, but not to ensure better enjoyment of right to health by individuals. This understanding broadens the scope of the principle of subsidiarity on the matter of health, and EU looses a possible chance to ensure better protection of right to health by the member states as it obliges itself to stay totally out.

3.2.1 Treaties and Charters

The first place to begin studying EU legislation on a subject is the founding treaties. Health is handled as part of many different areas in the treaties, such as consumer protection, environment, social policy, development policy and research. (Commission of the European Communities 2007a: 2) Public health as a separate provision entered into Union primary legislation with TEU in 1992. In the new consolidated version after TEU, a provision was added to the Treaty establishing European Community stating Union's role to contribute to health protection by encouraging cooperation between member states and giving them support when necessary. ("EC Treaty" Art. 129/1)[10] With the Treaty of Amsterdam this provision is amended in article 152 and community actions to complement member state policies are presented in a clearer and more specific manner. (Abbing 1998: 172) The objective of community action

[10] EC Treaty as consolidated by the TEU

is stated here more explicitly as "improving public health, preventing human illnesses and diseases, and obviating sources of danger to human health." ("EC treaty" Art. 152/1) [11] With the Treaty of Amsterdam the principle of ensuring human health protection in definition and implementation of all community policies and activities, is entrenched quite effectively. EU accepts that health policies alone are inadequate to guarantee health protection if health affects of other policies, such as trade, or environment are disregarded. In the latest consolidated version of the EC Treaty, which is now after the Lisbon Treaty (2009) called as the Treaty on the Functioning of the European Union (TFEU), this article is amended once more as article 168. This amendment brought even more clarification to Union's competences on health. While giving more details about Union's competences, it also added "management of health services and medical care, and the allocation of resources assigned to them" to the responsibilities of the states along with definition of their health policies, and organization and delivery of health services. Union's role is limited to complement national action. This is a result of the principle of subsidiarity. However, it may be criticized from a human rights perspective as being too indifferent to the human rights-appropriateness of the national systems and practices. This problem could have been overcome with additional provisions in the treaties or in other health documents putting more pressure on member states to follow right to health guidelines when preparing and conducting their health systems and services; however as we will see, there is nothing like this in EU health legislation. Lisbon amendments added certain new issues to article 168 such as cross border threats. As a positive sign there is also the inclusion of

[11] EC Treaty as consolidated by the Treaty of Amsterdam

the need to create, in cooperation with the member states, guidelines, indicators, periodic monitoring and evaluation systems and an organization of the exchange of best practice. This new paragraph shows that the Union has the intention to follow the system of monitoring that is required in human rights-based approaches. Similarly, the inclusion of the need for measures to set quality and safety standards for medical products and devices, which were addressed only in the framework of free movement of goods before (Abbing 2004: 314 endnote 21) also meets the right to health requirement of quality. However these good signs of compatibility with a human rights understanding in health cannot be generalized as to label the approach as human rights-based.

Health as a human right in the EU *acquis* is referred mainly in three places; the European Social Charter, Community Charter of Fundamental Social Rights of Workers, both of which were added to treaty law with the Treaty of Amsterdam as a reference, and the Charter of Fundamental Rights of the European Union. In 1997 the Treaty of Amsterdam amended the preamble of the TEU, adding member states' "attachment to fundamental social rights as defined in the European Social Charter signed at Turin on 18 October 1961 and in the 1989 Community Charter of the Fundamental Social Rights of Workers." ("TEU" Preamble)[12] With this addition, right to health became protected in the treaties although indirectly.

European Social Charter is a document of the CoE. As the counterpart of the ECHR, it is accepted in 1961 (revised in 1995) covering ESR which were not

[12] Preamble of the TEU as amended in the Treaty of Amsterdam

included in the former convention. It deals with the issue of health in the contexts of healthy and safe working conditions particularly for the children and women, social security, rights of migrant workers and the elderly. It recognizes the "right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable for everyone." (Council of Europe 1965, Part I) In its Article 11, it accepts the right to protection of health. However it is noteworthy that it does not assert any entitlements of the states to take necessary measures to ensure that citizens have all services and facilities for the realization of their right to highest attainable level of health.

Community Charter of Fundamental Social Rights of Workers is adopted by the European Community in 1989 in order to support the social dimension of the Single Market. It regulates the health and safety at work place, and recognizes the right to social protection. However, apart from these, it has no provision that deals with the right to health. The Charter of Fundamental Rights of the European Union, on the other hand, covers all the rights in ECHR and European Social Charter. It is "the most comprehensive human rights document yet to be adopted at the regional and international level *as it embodies both civil and political, and economic and social rights, as well as* provisions directed at particular groups such as the children, the disabled, and the elderly." (McBride 2005: 121) It was proclaimed jointly by the Parliament, the Council, and the Commission of the European Union, on 7 December 2000, therefore it came with a political weight, although it did not have a binding effect at the time. It gained legally binding character with the coming into force of the Lisbon Treaty in 1 December 2009. Health in the Charter reveals as part of the

working conditions, working children, and social security. Article 35 of the Charter is directly on Health Care. It says that

> “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.”

However, once again it is seen that this provision does not bring any direct responsibilities on the member states for the provision of required services and embracement of necessary measures to ensure the mentioned high level of human health protection, let alone the highest attainable level of health. In Article 51 which is on the field of application of the charter, it is expressed that the provisions of the charter addresses the institutions, bodies, offices and agencies of the Union. Member states are addressees only when they are implementing the Union law. (“Charter of Fundamental Rights of the European Union” Art. 51/1) Therefore, the Charter brings no direct responsibilities for the member states to respect the provisions and fulfil their requirements when they are acting within their domestic policies. This is a weak point from the view point of human rights protection because Union citizens’ rights are out of Union’s protection against the violations by their states except the implementation of the Union law.

3.2.2 European Health Strategy and Health Programme

EU has a mandate that it takes from the treaties to support, complement and add value to member state policies, and to maintain coordination. In 2002, based on the Article 152 of the EC Treaty, EU prepared its first public health

programme[13] which is then replaced by the Second Programme of Community Action in the Field of Health (2008-13). These programmes are the major instruments for the implementation of Union's health strategies. In this framework, it could be better to look at the Health Strategy and the Health Programme 2008-13 together. Examining their content and language in the light of and with regard to right to health would let a critical analysis of EU's approach to the issue of health.

Health strategy of the Union is built in the Commission White Paper Together for Health: A Strategic Approach for the EU 2008-2013. It sets four fundamental principles for action on health and three strategic objectives. Both the strategy and the programme seem compatible with right to health at first glance. However, when examined carefully it is seen that the human rights dimension is valid only for the Union level. Both the strategy and the programme are prepared duly in line with human rights principles, and the contents are compatible with right to health requirements to a certain extent. The problem is that this human rights concern is limited to the Union itself and does not go down to member state level.

Beginning with the good side, there are several points that human rights principles related to procedures and content and also a human rights sensitivity can be found. Participation, transparency, citizens' influence on decision making, environmental concerns, concern for water and air quality, food safety, gender issues, principle of equality, importance given to data collection and

[13] Programme of Community Action in the Field of Public Health (2003-2008)

information exchange are all such points that are in line with the right to health principles and elements as they are stated in the general comment No. 14. Similarly "addressing the health effects of social and environmental determinants" (Europa 2007: 5) gives the clues of an understanding of health which is very parallel to what is described in right to health documents. The goal of the programme being stated as aiming to contribute to "a high level of physical and mental health, greater equality, better access to information, and increased ability of individuals to make decisions" (European Parliament and Council of the European Union 2007: L301/4) is quite compatible with a right to health approach. However, almost all these points coming from right to health elements are valid solely for community-level such as this specific programme, and the actions caused by it. When they turn into responsibilities of the states at the national level, this is not a directly intended one trying to make the member states as right to health-respecting as possible, but just an unavoidable requirement of the community level policies and actions. As a result of the subsidiarity principle, EU deals only with cross-border, transnational, international, or community level issues, and its human rights concerns in health are limited to these areas only.

As stated in the programme, "under article 152 of the EC Treaty, the Community is required to play an active role by taking measures which cannot be taken by individual member states." (European Parliament and Council of the European Union 2007: L301/3) This statement expresses the case with the word 'cannot', but actually, there are no provisions to regulate EU's responsibility when the member states 'do not' accept necessary measures,

policies and practices to uphold its citizens' right to health in their health systems. For example, the programme expresses its concern for women and elderly by saying that "the programme should address gender-related and aging-related health issues" (European Parliament and Council of the European Union 2007: L301/6) but it does not say anything about states' requirement to be sensitive about other vulnerable groups in their health policies. Likewise, it encourages the participation of national, regional, and local authorities and of nongovernmental organizations and specialized networks to the implementation of the programme, (p. L301/6) but it does not express an expectation from the member states to respect the principle of participation in their health policies and health care provision. The same is true for the principles of transparency in implementation and equality. (L301/6-7) What is being expected from the Union institutions in terms of transparency and equality in health policies and practices, are not explicitly demanded from member states. Both of the documents limit Union's role to the areas of health which are out of member states' control, or where cooperation between states is indispensable. As a result of the principle of subsidiarity, everything about states' health policies and health care services are left entirely to member states. This, points to a problem in terms of human rights, because as the Union is not interested in the situations within the states, it cannot intervene even when there are serious right to health violations through acts of commission or acts of omission. It assumes responsibility in the face of cross border health threats, (European Parliament and Council of the European Union 2007: L301/3) however existence of people within the boundaries of a state who are unable to achieve fast, effective, good quality health care is an issue which cannot be left solely to

the sovereignty of that state when health is sincerely accepted as a human right. Looking from this perspective, the concept of 'cross border issues' changes drastically, because human rights has long been accepted as issues that transcend national boundaries.

Moreover, one of the major community level concerns of the EU in health, as we see in related documents,[14] is the easy access to healthcare without problems of reimbursement for every European citizen when they are travelling in Europe. This is essential for the enjoyment of the right to free movement. However, this requires a certain degree of standardization of methods and service qualities, if not the health systems, on the common denominator of human rights principles. Although human rights principles and guidelines could have been a convenient tool and reference for this standardization, there is no such effort in the side of EU to limit subsidiarity with human rights requirements. In fact, as for a perfect enjoyment of the right to free movement of people and of patients a better uniformity in service standards, in health rights, and in monitoring is indispensible, more EU involvement in health seems inevitable in the future. (Gevers 2004: 32) Such an EU involvement may also be a solution to the highly referred problem of resource constraints in ESR. Direct resource transfers, or more efficient resource allocation through the operation of the principle of free movement for a better utilization of the national resources and services would help relieving the possible resource problems that the member countries face in fulfilling their right to health duties.

[14] Such as the European Commission web page on Public Health: http://ec.europa.eu/health/index_en.htm

To summarize, what is crucially important is the fact that the Union seems more or less respectful to human rights principles in its own conducts and policies on the issue of health, but this does not reflect an understanding of health as a human right, because it closes its eye to the possible right to health violations within the member states. Human rights regimes regulate the vertical relations between the state and its citizens. Thus an understanding of health as a human right would require the Union to be more careful and sensitive about this vertical relationship within its member states. Member states are supposed to be the primary responsibles with regard to human rights, including the right to health; however the Union does not explicitly express an expectation from them to fulfil their duties of right to health. It is known that unlike the issue of health, EU is normally quite strict about the issues that it sincerely considers as human rights, such as the case with its actively regulatory role in civil and political rights like freedom of expression, or the habeas corpus rights.

A possible reply to this criticism here could be a referral to the Council Conclusions on Common Values and Principles in European Union Health Systems (Council of the European Union 2006), which has also been taken as a reference in the preparation of the current health programme of the Union. This document which was prepared in 2006 with the participation of 25 health ministers of the member states puts forward the values and principles that are common in all health systems in Europe. All four common values, which are universality, solidarity, equity and accessibility, have matches in right to health documents. Therefore it can be said that a right to health understanding, and a human rights sensitivity in matters of health already exists in member states by

itself, and there is no need for an explicit community dictate to make it that way. However, it may be necessary to 'keep' it that way. Moreover, obviously, endorsing certain values in theory, or even in law, does not automatically mean respecting them in practice. Especially for an enlarged Europe of more than 10 East European countries this is even truer. Just as a small example, share of the population perceiving an unmet need for medical examination or treatment is 25.2% for Bulgaria in 2008. (Eurostat) This dramatic number very clearly points to hundreds of thousands of people who do not have adequate access to health care for some reason, and this is contradictory with both the common values, and the right to health. Therefore only the expression of respect for these values do not justify EU inaction in observing and enhancing people's right to health in member states.

A recent but prominent concept which needs to be touched upon when talking about health in EU is the Health in all Policies strategy which has been put forward in Finnish Presidency in 2006. Acknowledging that the goals of the public health policy as stated in article 168 of the TFEU cannot be possible only through health policies, health is incorporated into all other policy areas, from transportation to fisheries. Nearly all policy areas have impacts on health or determinants on health, e.g. water, food, environment, etc. So Health in all Policies was a required strategy to create joint initiatives and partnerships between health and different policy areas, and achieve high level of health protection. However, although the strategy aims to address policy making both at community and national levels, (Puska 2007: 328) once again it remains weak at the national level, as state level implementations are left to national

decision makers only. At the community level, although health is easier to incorporate in certain policy areas, such as environment or labour, in other areas, especially the ones with contradicting interests such an integration is highly difficult. Common Agricultural Policy is one of such policy areas where health implications like obesity, cholesterol, or use of tobacco products are hardly being taken into consideration. (Ollila 2006) In this sense, in the literature Health in all Policies is accused of "remaining mostly as rhetoric" (Koivusalo 2010) at the community level.

In fact despite the closeness to right to health at some points, the general impression in EU public health documents is that the primary importance of the issue for the Union comes from its relevance to the operation of the single market. Although health has a relatively more prominent place in the political agenda since late 1990s, as compared to the earlier years of the Union, when nothing but the economic considerations drove the Union policies, (Editorial 2005) the improvement of the place of health is only relative. The matters of the single market, economic integration, free movement of goods, services and people constitute the core of the issue of health in the EU. Community policies and programmes related to health aim mainly to solve health-related obstacles in front of the smooth functioning of the single market. In the commission staff working document accompanying the white paper on health, it is stated that "working towards the EU's fundamental mission, to enable free movement of people, goods and services, and to cooperate on cross border issues requires the consideration of health issues." (Commission of the European Communities 2007b, Executive Summary) The fact that the issue of health is not held as part

of human rights, but under consumer protection, food safety, internal market, etc. also shows the market-oriented approach to health. For example, in the health programme, preventing diseases and promoting healthier ways of life is explained to be required for the well being of EU citizens as well as for dealing with increasing costs of health care and social security. (European Parliament and Council of the European Union 2007: L301/4) Similarly, in the health strategy white paper, one of the four principles is about the importance of health for economic productivity and prosperity. (Commission of the European Communities 2007a: 5) Likewise, one of the objectives in the white paper, which is about promotion of good health, concentrates on the economic impacts of the aging population such as increased health care spending or decreasing working population. (Commission of the European Communities 2007a: 7) All the proposals within this objective, to enhance the health of the population aims to tackle these kind of problems rather than trying to maintain the highest attainable standard of health for everybody of every age, just because it is an inherent human right of them. When we look at the literature on health in EU, again we see that cross border health services, which is mainly about free movement of workers, is a more popular subject than health as a human right. This emphasis on the connection between health and economic prosperity sees individuals as means (to the end of economic prosperity) and not as ends in themselves, and theoretically even this approach itself is quite irreconcilable with a human rights approach.

CHAPTER IV

RIGHT TO HEALTH IN TURKEY

4.1 Socio-economic Portrait of Turkey

Before examining the case for the right to health in Turkey, in order to put it in a context it is better to begin with a general social and economic portrait of Turkey. ESR in Turkey are protected at the constitutional level. One of the irrevocable provisions of the 1982 constitution characterizes the state as a "social state", which can be defined as "an understanding of state that aims to provide to everyone a life compatible with human dignity." (Gozler 2000: 155) Such an understanding itself constitutes a direct connection between ESR and the "Fundamental Aims and Duties of the State"[15], as the principle of protecting human dignity lies at the foundation of human rights, as well.[16] Along with CPR, constitution of 1982 explicitly recognizes many ESR. Chapter Three of the constitution, which covers articles 41 to 65 is titled as "Social and Economic Rights and Duties" and it covers almost all the internationally recognized ESR. Everyone's right to work, right to social security, right to housing, right to education, right to property, right to rest and leisure, right to

[15] Heading of the Article 5 of the 1982 Constitution. Article 5 explains what to understand from the "social state" characterization of Article 2.
[16] As seen in the preamble of the 1948 Universal Declaration of Human Rights

organize labour unions and children's rights are all referred with the "right to x" formulation, so are explicitly recognized as rights. Curiously enough, although health is also handled in the same chapter, this right to x formulation is not used for health. Title of the relevant article, namely article 56, is "Health Services and Conservation of the Environment" and it talks about the duty of the state to "regulate central planning and functioning of the health services to ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity."[17] ("Constitution of the Republic of Turkey 1982, Art. 56)

Besides the constitution, Turkey is also a signatory of many global and regional human rights documents. It has signed and ratified the ICCPR, ICESCR, CAT, CERD, CEDAW, CRC, Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, Convention Relating to the Status of Refugees, and the Convention on the People with Disabilities.[18] It is also a party to ECHR with many of its protocols, and accepts the competence of the ECtHR. In the art. 90, Turkish constitution recognizes that the provisions of these international human rights documents are above the constitutional provisions in case of a contradiction between the two. Hence, the legal protection of rights is quite strong in a legal-positivist sense.

However, turning to the actual situation in the field the scene is not really that bright, especially for the enjoyment of ESR. When the world is observed from

[17]Sentence rearranged to add emphasis.
[18] Source: United Nations Treaty Collection, http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en

the outside, socio-economic view of Turkey, as a devoted EU candidate, seems very incompatible with Europe; at least as much incompatible as its democracy and civil rights report. Even the biggest, most developed cities, which reflect the Western face of Turkey, accommodate great ESR violations in poorer neighbourhoods. Poverty is a vitally important problem of Turkey. So much so that for a significant number of people, and for large geographical segments, poverty may itself be considered as a rights violation. According to Turkstat, official statistical institute of Turkey, with 2008 numbers 0.54% of the population is living below hunger line, and 17.11% below poverty line. These rates are even higher for rural areas with 1.18% and 32.62% respectively.[19] (Turkstat 2009) To compare the situation with the EU, the only reference year we have is 2003, because in the relevant Eurostat database, it is the only year that has the data for both EU and Turkey. According to Eurostat, 15% of the population within EU25 live at risk of poverty after social transfers while for Turkey the ratio jumps to 26%. This rate of Turkey is the highest in the table, which includes member states and some non-members in the period 1996-2007.

As to income distribution, which is another indicator of social and economic conditions of a middle income level country, Turkey has the worst grade in Europe. In 2008 the income share of the top one fifth of the population with the highest income is 46.7%, while it is 5.8% for the lowest income quintile. Therefore the inequality criteria, which is the ratio of the income share of the highest income quintile to the income share of the first quintile with the lowest income, is 8.1 for 2008.(Turkstat 2010) For a comparison with the EU, this

[19]Hunger line here refers to the food poverty which is accepted as 275TL per month for four-person household. Poverty line refers to both food and non-food expenditures and is accepted as 767TL monthly income for four-person household.

ratio is 4.6 for EU25 in 2003, while it is 9.9 for Turkey in the same year. Once again this is the highest figure in the whole table. Considering that per capita GDP in Turkey was 3372 dollars in 2003, the impact of such an unequal distribution on the lower income segments of the society can be realized.

Education is a crucial element in the socio-economic structure of any country both in terms of individual rights, and societal development. In Turkey it has significant deficiencies. Adult literacy rate of Turkey according to 2007 numbers is 88.7%. (UNDP 2009) An illiteracy rate of 11.3% is unacceptably high and is the highest in EU27. Net schooling ratio in primary education is 96.49% in 2008/09. However, after the obligatory primary education, the ratios decrease significantly. Before the EU adjustment law which increased the obligatory primary education to eight years, the situation was even worse, because these people who do not continue their education used to drop school three years earlier, in only five years. According to Eurostat, percentage of population aged 25-64 having completed at least secondary education in 2007 is 71.5 for EU27, whereas it is only 26.6 for Turkey. This rate is far behind the EU Lisbon target which aims to have 85% of 22-year-olds completed upper secondary education (high school) by 2010. Educational attainment in Turkey is among the lowest of OECD. (Aksit 2007: 131) EU also points this in 2007 Progress Report saying “while the top students in Turkey perform well, (…) the distribution of Turkish scores is highly skewed toward the lower levels of proficiency in basic competencies and problem solving.”(p.31)

To see the issue from a rights-based perspective, the most accurate references can be taken from the general comment of the CESCR (1999) on the right to education. Here, the essential features of education as a human right are listed as availability, accessibility, acceptability, and adaptability. In Turkey, as to availability, the situation needs enhancement in rural areas, especially of east and southeast. As to accessibility, there is free primary and secondary education for everyone. As one of the Progress Reports (2000: 58) also put it, legal and regulatory framework for universal education consistent and coherent with EU member states is extant, not letting any de jure discrimination. Turkish education system is mostly criticized in the acceptability element, because of the policies regarding cultural aspects of the system, namely the prohibition of education in one's mother tongue other than Turkish and biased obligatory religion lessons. Both of the issues, especially the former are issue of concern and debate both within Turkey and for the EU. Equality in education is more of a practical problem of gender and regions. Although considerable improvement has been made, women still constitutes a smaller portion in schools than men. The ratio of illiterates in the population older than 23 is 4.08 for men and 20.67 for women. (Bakis *et al* 2009: 4) According to the same study (p.22), the reasons for the low levels of enrolment of women even to primary education, which is obligatory, may be listed as the existence of traditional social structures, low levels of income, inadequacy of the education system in giving qualifications, and the difficulty of achieving good quality education. Beside education, unemployment maybe taken as a basic sign of the gender inequality in participation to economic and social life, which no doubt effects women's full enjoyment of their rights. Unemployment rates as of January 2010 is 14.5%

for both men and women. However, employment rate for men in the same period is 40.6 whereas for women it is 22.1. (Turkstat)

Regional differences are also striking in education indicators. Student to teacher ratio[20] for Turkey is 22.3 while it is way behind it in Southeast Anatolia region with 30.09. (Tursktat) Similarly while the number of teacher per school is 10.2 in general, it is 7.5 for southeast. This has reflections in the education levels, as well. Eastern Turkey, especially southeast has significantly lower education levels than the rest of Turkey. Almost one third of all population older than 23 in the east of Turkey cannot even read or write. (Turkstat) The underlying reasons of this situation is out of the scope of this paper, however the reasons listed for women’s education, such as dominance of traditional structures and socio-economic development levels are valid for regional disparities, as well.

4.2 Health and the Right to Health in Turkey

Actual existence of a right is an issue of both laws and practice. This is true for the right to health as well. An appropriate legal approach to the issue and adequate regulations for the full enjoyment of the right are requirements, but not the only ones. General health of a population, characteristics of a health system, and consistent problems in the service of health care may all be indicators of the degree of the actual enjoyment of the right to health by the people. Turkey, since 1961 Constitution refers to health under the title of “Social and Economic Rights and Duties”. Article 49 of the 1961 Constitution

[20] Pre-school, primary school, and secondary school combined. Total number of students is divided by the number of teachers.

is titled as “Right to Health” and acknowledges “state’s duty to ensure everyone to be able to live with physical and mental health, and achieve medical care.” 1982 Constitution, unlike its predecessor does not use the expression “right to health.” The right in Article 56 is only arranged as “the right of everyone to live in a healthy, balanced environment.” The “duty of the state” rhetoric of 1961 is changed and it is expressed that the “state plans and regulates the health institutions”. This change may be attributed to the liberalization trends and market-oriented reforms of the period. (Yasar 2010: 3) When compared to 1961 Constitution which recognizes state’s duty -thus people’s right- for physical and mental health and for medical treatment, this rearrangement of the phrases actually changes the understanding towards a weaker emphasis on the fundamental human right framework. However we do not see a reflection of it in the form of a backward step in right logic in health. Other legislation on health, 1961 Law on the Socialization of Health Services (Law No. 224), 1987 Fundamental Law on Health Services (Law No. 3359), 2006 Law on Social Insurance and Universal Health Insurance (Law No. 5510) never use the expression “right to health”. But the law of 1961 recognizes that health is a right in the UDHR. Law of 1987 includes many elements common with right to health, such as equal, qualified, efficient health service; standard setting; continuing in-service education for the personnel; consciousness raising for the citizens, etc. 2006 Law on Social Insurance, as well, reflects a portrait pretty much appropriate to right to health, except possible problems regarding inequalities and coverage[21].

[21] These problems will be touched upon later in this chapter.

Turkey is a member of the WHO, accepting its constitution with the wide, holistic definition of right to health that it gives. Additionally many of the international documents that Turkey is a party, such as the ICESCR or CRC explicitly recognizes the right to health binding Turkey with all the requirements thereof. However many different indicators on the subject show that a full enjoyment of this right by everyone is yet to be achieved in Turkey.

To begin with, life expectancy at birth for Turkey is 72.5 years, while it is 78.82 years for the EU in the same period. (CIA 2011) According to a recent OECD report on the health system of Turkey, life expectancy at age 65 is 75% of the OECD average for women and 78% of the average for men in 2006. In the same report life expectancies at age 65 are the lowest for Turkey in OECD area[22], with 15.1 years for women and 13.1 years for men. (2008: 60-61) As to infant mortality, Turkey has a bad record with 23.94 per 1000 live births. This is a very high number pointing to the poor status of health in Turkey. For the EU, this number is only 5.61.(CIA 2011) This figure is the highest among all member and candidate countries of the Union. "Not only in Turkey but in all countries, life expectancy and infant mortality rates are viewed as essential indicators of social advancement, public health, and the quality of health care systems." (Kisa, Kavuncubasi, and Korkut 2002: 92) Therefore it is interesting not to see a strong EU emphasis and a pressure for the enhancement of this situation in Turkey.

[22] OECD area includes 19 of the EU states plus 11 other OECD members.

Moving from health status indicators to health care system indicators, the scene does not change. Number of persons per physician is 637. This is 836 for nurses and 2965 for pharmacist.[23](Turkstat) According to Eurostat data, in 2004, the number of hospital beds per 100 000 inhabitants is 595.9 for EU27, while it is less than half of this figure for Turkey with only 241.2 beds. As to health personnel[24] rate per 100 000 inhabitants, we do not have an EU average in Eurostat database, but Turkey has the worst number again with 139.3 in 2003, the latest year with Turkey's data. This is only two-thirds of the second worst, which is Romania with 199.6. As another good example to demonstrate Turkey's backwardness in healthcare facilities and providers, the OECD report suggests that "physician density, at 1.6 per 1000 population, was lower in Turkey in 2006 than in any other OECD country. Physician density in Turkey was at about half the OECD average in 2006." (2008: 75-76)

Along with such factors directly tied to health, in order to draw a full picture the indicators regarding the underlying determinants of health which are referred in the General Comment on the Right to Health should not be ignored. As of 2005, 0.87% of the population (more then 600.000 people) is unable to satisfy their minimum nutritional needs. The proportion of population without sustainable access to an improved water source is 5.2% and without sustainable access to improved sanitation is 17.4%. Of the total 15.070.093 housing units 874.984 have no piped water, and 170.886 have no toilets be it inside the house or out. (Turkstat) These figures indicate a significant number of people devoid of the most fundamental requirements for their highest attainable level of

[23] With 2006 numbers.
[24] Excluding nursing and caring professionals

health, thus a significant incompetence in fulfilling the requisites of the right to health in part of the Turkish state.

4.3 Health System in Turkey

Health system in Turkey is comprised of two main actors, the Ministry of Health and the social security institution. Prior to the reformation process that began in 2003, there were three different social security institutions covering blue-collar workers in the public and private sector (SSK), the self-employed (Bağ-Kur), and retired white-collar government employees (Emekli Sandığı). Active civil servants were directly financed from the state budget. There was also a green card programme, for the poor who are out of any social protection scheme and unable to pay for their health services. All these different groups had different health benefit packages that they could utilize, not quite compatible with the principles of equity. In this disperse system, there were still a significant number of people without any sort of protection. According to the State Planning Organisation this number was 15% of the population in 2003, and according to the Turkstat it was 36%. (OECD 2008: 30)

Provision of health services prior to 2003 was dispersed as well. There were three agencies responsible from providing health services; the Ministry of Health, the SSK, and universities. Primary health care and preventive health services were almost exclusively under the responsibility of the Ministry of Health. The primary health care facilities, namely the health posts and health centres in rural and urban settlements of different population sizes were living significant problems of resources, and personnel training. Primary care

facilities were planned to be distributed among the population, however difficulty of this is evident as both the facilities and the medical staff tend to concentrate in certain geographical areas and in urban settlements. (Yardim *et al* 2008) As the referral system was very ineffective people tend to go directly to upper level health facilities bypassing the primary level. (OECD 2008) This was a major cause of inefficiency and a major reason of overcrowd in the public hospitals, especially in Ministry of Health hospitals and SSK hospitals. Despite the overcrowd in outpatient services, hospital occupancy rates were about 60% and the average length of stay in hospital was about 5.9 days in 2002. (OECD 2008) There were also private health services that were established after 1980s and concentrated mainly in the largest cities. They were mainly financed by the patients. Some of them had contracts with social security institutions. Access to health services in rural areas was more difficult and expensive in rural settlements then they are in urban. (OECD 2008: 37; Chakraborty 2009) "57% of rural households found it difficult to reach a health facility because of transportation costs."(OECD 2008: 38) Another major criticism that different analysis agree on was the problem of financial inefficiency of the system caused by the high expenses on more costly curative services, rather then preventive care. (OECD 2008; Pala 2007) Both financial and practical emphasis on inpatient and outpatient services in hospitals creates inefficiency in the system which hampers the effective utilization of primary health care services.

Need for out-of pocket payments is another criticism that the OECD and the World Bank directed to the pre-2003 health system. Incomprehensiveness of

the insurance systems, both in terms of their benefits and their population coverage obliged people to finance their health expenditures themselves wholly or partly. An inverse care law[25] was in place here, as the ones that have to pay their health expenditures directly from their pockets, were the poor and vulnerable with green card, and the ones who does not have insurance, which in many cases means that they do not have a regular income. “For example individuals in the lowest two quintiles used to pay on average 27TL for a visit to a health centre as compared with approximately 13TL for individuals in the two highest quintiles.” (OECD 2008: 38)

4.3.1 Post-2003 System: Health Transformation Programme

As a continuation of the health system reform intentions and attempts which are accelerated in the late 1980s, in 2003, a reform programme in health system, which was deeper and more comprehensive then the previous ones was initiated. This reform programme is in parallel to IMF and ILO recommendations and the World Bank guidance, especially to the Health Systems Strengthening scheme that the World Bank embraces for its health agenda. (Elveren 2008: 219; Bugra and Keyder 2006: 216; Yasar 2010: 7) Some of the main components of the reform programme (Yardim *et al* 2008) are:

- Restructuring of the ministry of health by giving an end to its provider function and leave it with the regulatory, supervisory, and researcher responsibilities

[25] Inverse Care Law is a concept of Julian Tudor Hart. As quoted from the abstract of the relevant article, it argues that “the availability of good medical care tends to vary inversely with the need for it in the population served.” Hart, Julian T. 1971 “The Inverse Care Law” *The Lancet.* Vol. 297. Issue 7696

- Launching the Universal Health Insurance to cover everyone equally instead of the previous dispersed insurance schemes which leaves many without protection
- Strengthening preventive and primary care systems through a family medicine system, an effective referral system, and more autonomous public hospitals.

Basic principles of the transformation programme as indicated by the ministry of health, at least on paper, are compatible with and contributory to the enhancement of the right to health. Human-orientedness, participation, conciliation, continuous quality improvement are directly related to the right to health; volunteerism and decentralization would also enhance the overall right to health situation. Within this framework, a performance-based payment system for the physicians is introduced to improve efficiency as a solution to the problem of physician/patient ratio in 2003. In 2004 green card holders are taken into coverage for outpatient services, and then for outpatient prescription drugs. In 2005 SSK members are allowed to utilize private pharmacies. In the same year SSK hospitals are transferred to the ministry of health, and SSK became only the purchaser of health services, not the provider of them. As the major move to strengthening the referral system and primary care services, family medicine system is introduced in pilot cities beginning from 2005. Universal Health Insurance (UHI) began to be implemented in 2008, although not all the planned aspects are yet included in its coverage, such as the green card holders who are not yet in the system although they have more benefits as compared to before. (OECD 2008)

However, these changes came with harsh criticisms despite the apparently positive immediate outcomes. Major criticisms are concentrated around the idea of liberalizing the health services. Members of the main opposition party[26], some of the major professional unions in the area[27], and certain labour unions of the sector[28] have been expressing their concerns regarding the decreasing role of the state, and increasing commercialization of the health sector. It is strongly claimed that the Health Transformation Programme (HTP) and the Law 5510 on Social Insurance and Universal Health Insurance obliges health to be dealt in a market structure. When health services system becomes a market, health becomes a commodity and the patients become clients. This understanding is incompatible with health as a human right, because in such a case the ones that do not have money cannot access to health services, and the ones that do have money can only get as much health care as their money can get. (Pala 2007: 16) "To deny health care to a patient only because he does not have money or some sort of health insurance simply means ignoring the acceptance that health is a fundamental human right." (Pala 2007: 15) In the same direction, one of the major goals of the programme, to limit state's role to regulation and supervision attracts reaction. The retirement of the state from health service provision would only facilitate transformation of the health sector into a commercial area that is shaped by profit maximization and supply-demand relations, and this structure is highly incompatible with the health care sector. (Pala 2007: 25) It is argued that family medicine system at the primary

[26] Neşşar, M. "Basına ve Kamuoyuna Duyuru: Türk Hekimleri bu nedenle baştan beri GSS yaklaşımına ve onun göstermelik aile hekimliği modeline karşı çıkmaktadır" 13.04.06 http://www.turkpartner.de/D/6/MnsKrs.htm Last Access: 10.02.2009

[27] Turkish Medical Association (Türk Tabipleri Birliği- TBB), Turkish Pharmacists' Association (Türk Eczacıları Birliği- TEB), General Practice Association (Pratisyen Hekimler Derneği)

[28] Union of Health and Social Service Labourers (Sağlık ve Sosyal Hizmet Emekçileri Sendikası-SES)

level, and giving autonomy to public hospitals at the secondary level practically means privatization (Adar 2007: 168; Pala 2007; Ozturk and Celik 2008) and serves for the same purpose of commercializing health. If this becomes the practical reality it would cause a serious disadvantage of the poor and vulnerable.

Another point that is feared to be very disadvantageous for the poor at some point in the future is the fundamental benefits package, which determines the limits of the health services to be covered by the social security. It is argued that financial concerns will surpass the interests of the people sooner or later, (Elveren 2008: 220-21), and that the content of the package will most probably shrink by time, after the period for people's adaptation of the new system is past. (Bugra and Keyder 2006: 216; Pala 2007: 22-23) Turkish Medical Association shares these concerns arguing that although the package according to the current law is not restrictive of the right to health as it has a wide coverage excluding only the operations for aesthetic purposes, the general framework of the reforms suggests that in the future this package will be narrowed and will leave much more space for private health insurances. (Ozturk and Celik 2008: 40) Such a situation would create big inequities in the population, leaving millions, including the ones with social protection, in difficulty. More politicized, hence harsher and more provocative arguments as of a former CHP parliamentarian suggests that the underlying aim of the fundamental benefits package is to serve the benefits of the international drug corporations. They suggest that it will make people use drugs unrestrainedly by making it difficult to achieve a doctor. (Nessar 2006)

Social Insurance and Universal Health Insurance Law is also criticized for being different from the initially intended version in details, and being applied differently from the promised applications. First of all the strongest claim for the UHI is that it will end the disparities in social security and will cover everyone without leaving anyone out. However new regulations do not include workers in the informal sector or unemployed who cannot get an unemployment insurance. (Ozturk and Celik 2008: 38) Although the law says that the premiums of the people who are unable to pay will be paid by the state, who to consider as "unable" is an issue. Currently, people whose per capita monthly income in the family is lower then one third of the minimum wage are considered eligible for this. However such a limit would mean the denial of access to health for many who are unable to pay their premiums although they are expected to do so, which in Turkey's conditions according to Kayıhan Pala (2008), may mean millions of people. Turkish Medical Association also claims that new regulations will cause loss of right for certain groups. For example although there was a positive discrimination for women in the previous laws, which guarantee protection for the girls through their parents until they get a job or get married even after 18 years old, in the new law girls in that condition will loose their health security. Considering the low levels of women participation in labour force, the inconvenience that the removal of this positive discrimination creates is clear. (Ozturk and Celik 2008; Turk Eczacıları Birligi 2009) In such a case this would be a retrogressive measure, which is unacceptable from a rights based approach as has been expressed in the general comment No. 14.

Another much criticized issue is the out-of-pocket payments by the patients for many services that are actually within the benefits package. These additional payments are being considered necessary for a well-functioning referral system (you pay the fee of the service if you go directly to a secondary level health centre by-passing the primary level). However Turkish Pharmacists' Association points out the fact that the patients must pay a certain amount even when they are moving within the referral system, and claims that it is unnecessary for the stated purpose of these payments. (Ozturk and Celik 2008; Turk Eczacilari Birligi 2009) These payments are particularly problematic for the poorest of the society. A recent research by Erus and Aktakke (2011) showed that after the reforms the ratio of patients making certain amount of out-of-pocket payment has increased, and the share of health expenditure has increased the most for the lowest income groups. The co-payment for prescribed drugs which have not changed with the reforms contributes to this out-of-pocket health expenditures.

Performance-based supplementary payment system for the health personnel is also an interesting subject that has attracted strong reaction of the doctors. It is a model for increasing efficiency and for a better use of the health personnel at hand as a solution to low doctor/patient ratio. However, current regulations on this system do not answer the fears for the possible unnecessary treatments and operations; tendency to spend less time on a patient; possible increase in medical mistakes; or unnecessary expenditures to induce demand and this gives way to concerns. (Erus and Aktakke 2011: 4; Pala 2007: 30) The 25th February

2011 demonstrations by the junior hospital doctors in Ankara reacting to the initiation of the performance-based system in university hospitals (Turk Tabipleri Birligi 2011a), and the 13th March 2011 mass meeting of Turkey-wide doctors and other health personnel again in Ankara against performance based system and commercialization of health services shows health providers' discomfort about the new system. (Turk Tabipleri Birligi 2011b)

The financial aspects of the new health system are questionable for different evaluators. OECD report, while generally is satisfied with the transformation programme and the developments in the health system puts forward its concerns about the economic sustainability of the programme. "The most important remaining challenge facing the health system in 2008 is how to improve health status further. (…) A related challenge is how to do this while maintaining the sustainability of public spending on health. Because of the design of the new health system, there appears to be a high risk of cost-containment crises in the years to come, potentially exacerbated by downturns in the rate of future economic growth." (OECD 2008: 14) From the opposite side, analysts who are critical towards the Health Transformation Programme, question the very fundamentals of the system and argue that financing the health system by premiums is not suitable for Turkey. They argue that with high unemployment rates and a large informal sector, premium system is not effective and efficient neither for the state, nor for the patients. (Ozturk and Celik 2008: 36) It is argued that financing the health expenditures with taxes would provide a more equitable and wider protection especially for the poor. This criticism towards financing health through social insurance systems rather

then taxes is actually a very relevant and important one from the view point of human rights, so it will be evaluated in more detail later in this chapter.

As mentioned before the principles of the HTP on paper are pleasingly in line with the right to health. If this conformity is sincere or only rhetorical is mostly to be seen in time. If the criticisms towards the new system turn out to be rightful about the situation of the poor, coverage of the benefits package, commercialization of health, etc, human rights-respecting statements in the laws will be irrelevant. About the sincerity of the policy-makers in their respect to human rights, one might find some signs looking at the laws. For example the structure of the Price Determination Commission, which is responsible for determining the costs and setting the prices of the health services to be paid by the insurance, is composed only of representatives of ministries and undersecretaries without any member of a NGO or a health professionals' union. This structure undermines both the principle of participation and patient interests (Turk Eczacilari Birligi 2009) which are both mentioned in the official blueprints of the reforms.

People's understanding on the protection of the rights by the state does not reflect a satisfaction either. The document of the "Numerical Data on the Applications on the Claims of Violation of Human Rights" by the Human Rights Presidency (Prime Ministry of Turkey Human Rights Presidency 2010) showed that for the first six months of 2010, right to health has the first rank with 493 applications for alleged violations, followed by the prohibition of bad treatment with 235 applications. Of the total 3461 applications 611 are related

to right to health, patients' rights and social security rights. Similarly the health institutions are the first in terms of the number of complaints. These ranks were similar for the previous years, as well. (Prime Ministry of Turkey Human Rights Presidency 2008: 22) High number of right violation claims becomes even more significant when seen together with right awareness studies. Quantitative studies showed that a big majority of the people subject to study do not know their rights as patients. While a study (Zulfikar and Ulusoy 2001, abstract) reveals that "only 23% of the participants were able to recognize patient rights" according to another one (Tengilimoglu, Kisa and Dziegielewski 2000, abstract) "63% of the patients were not aware that they had any rights in receiving health care services at all." The violation complaints are so high although the level of awareness of the rights when getting health care is so low. Hence it is not difficult to anticipate the actual level of discomfort including the people who are not even aware that they can demand better treatment and conditions. The complaints subject to the applications in Human Rights Presidency reports (2008: 22) are "disinterest towards the patients in the hospitals, bad treatment conditions, long waiting queues, hygiene problems, wrong treatments, and technical impossibilities." It is very interesting to see that the Human Rights Presidency report (2008: 22) evaluates this table quite positively, saying that ESR are high on the agenda of the people only in the countries where "democracy and rule of law principles are deeply rooted and complaints related to other fundamental rights and political freedoms are relatively low." This evaluation is not only prejudiced but also harmful. It assumes an understanding of human rights in which ESR comes secondary after the civil and political ones and presumes that people's demand for ESR,

and annoyance by their violation comes only at the point when they fully enjoy their CPR. Although being embraced by many in the human rights literature, this understanding is highly controversial and may be strongly criticized. Such an approach in the report shows the tendency to see high numbers of alleged right violations in health as normal, and does not invite an enthusiastic examination for the causes of people's discomfort and an enhancement of the system for a more human rights-sensitive one. What is done with such an assessment of the people's complaints simply means closing eyes both to CPR situation (which by no means is perfect in Turkey) and the economic and social right deficiencies.

4.4 Evaluation of the Health System in Turkey from the View Point of Human Rights

4.4.1 Turkey and the Basic Principles of Right to Health

Recalling that the basic elements of the right to health as stated in the general comment are availability, accessibility, acceptability, and quality, the system as so far described may be examined in the guideline of these principles. As of availability, there is no doubt that Turkey has health personnel, hospitals, clinics, drugs, and insurance systems. However sufficiency of them is questionable, considering for example the fact that there are 158.22 physicians per 100000 people in 2008 when EU average is 323.71. The numbers for hospital beds are 240.73 in Turkey and 530.53 in the EU. (WHO Regional Office for Europe-a) Distribution of them is also problematic in terms of urban-rural and regional divides. "One third of hospital beds and almost half of all

doctors are concentrated in the three largest cities. (…) Specialists are most unevenly distributed: Istanbul has almost 14 times as many specialists per capita as the eastern provinces of Muş and Van." (WHO Regional Office for Europe 2004: 6) East of Turkey and particularly Southeast Anatolia has a remarkable disadvantage in health. Number of hospital beds per 100000 capita in 2007 is 262 for Turkey, 258 for Istanbul, 272 for Aegean region, however only 160 for Southeast Anatolia. Likewise, according to Turkstat data, the number of health personnel[29] per 100000 capita in 2004 is only 257 for southeast, and 311 for East Anatolia while it is 451 for Turkey in general. Although its effectiveness is questionable, HTP does not close eyes to this problem, and to solve this it regulates the performance measurements with a geographically-sensitive manner providing incentives to health care facilities away from the centres. As another issue, access to water, which is an important aspect of right to health, as well as other rights, is also more of a problem in certain regions as compared to others. By 2006, water is actually a country-wide problem. The ratio of rural settlements with adequate drinking water[30] is only 0.80 for Turkey. Ratio of the population living in these settlements[31] is 0.87. These figures, which are striking enough for an upper middle income OECD country at the door of the EU, are 0.69 and 0.81 respectively for Southeast Anatolia. ("General Directorate of Rural Services" 2006) These cannot be ignored when evaluating availability.

[29] Number of health personnel is calculated by adding up the numbers of specialist doctors, medical practitioners, dentists, pharmacists, medical officers, nurses and midwifes.
[30] Number of rural settlements with adequate water divided by the number of all rural settlements
[31] Number of population in these settlements divided by total population in all rural settlements

As of accessibility, the situation is similar. Because of geographical and topographical reasons and infrastructural deficiencies access to a health facility especially to a secondary and tertiary one might be very difficult for someone living in rural areas. Health care is more expensive and harder to access in rural. (World Bank 2010) This situation is even more intense in less developed regions, and for the poor and vulnerable groups for whom the burden of expenditures for access is hurtful. Another mostly ignored point is the persons with disabilities. There are countless hospitals to which access to main entrance or even to ER is with high steps, which makes access literally impossible for the disabled. The HTP does not seem to be bringing concrete positive discrimination for the people living in rural, in less developed regions, and for the people with disabilities. Moreover, if the fears of the critiques who find the new UHI system too neo-liberal and market-oriented are realized, such disadvantaged groups might be expected to end up worse-off. As the logic of the market forces is driven with profit maximization, seeing health facilities in places in far rural areas where there are few "clients" will be quite unlikely. However as a positive contribution to access to health, the reforms opening all public hospitals (including former SSK hospitals) to everyone, and including private hospitals to insurance benefits reduced the overcrowd and unacceptable waiting times in the hospitals. Once again although an effective solution may still be lacking, there is an improvement for the accessibility principle with the HTP.

In terms of economic accessibility, as explained before, there are many rightful concerns for the poor. The premiums of the very poor people whose monthly

income is below one third of the minimum wage will be paid by the state. So the danger about them is a possible shrinking of the benefits package in the future, which will make them unable to achieve certain treatments. For the poor who earns less than the minimum wage, but more than one third of it the problem of economic accessibility is immediate and serious, as it is very likely that they will be unable to pay their premiums (which will be calculated over the minimum wage) and find themselves without any sort of protection. The new regulations of UHI create this same danger for the self-employed whose incomes are not stable and very vulnerable against economic crisis periods, or for the unemployed people who are over 18 but not students. There is no doubt that this new system will benefit certain segments of the society, but the people that it is going to put in difficulty cannot be ignored. So although the first glance to the law gives a good impression in terms of economic accessibility, it is actually one of the most problematic points hidden in the details.

As of information accessibility, there are developments with the new system as one of the components of the HTP is to create a health information system to make access to effective information possible. (Yardim *et al* 2008: 276) It will be an important development for right to health when the Health Information System of Turkey/e-Health is fully and effectively realized as indicated within the strategic targets of Ministry of Health Strategic Plan. (2010 p. 77) Acceptability is not a major issue in Turkey as there are no indigenous or fundamentally different cultural groups with a very distinct understanding of health and health care. As to quality however, there are criticism from many centres (Tekneci 2003) mainly on the decreasing number of well-trained

physicians. Still it should not be overlooked that quality is a major concern in the Ministry of Health Strategic Plan 2010-2014, (Tatar and Kanavos 2008: 21) albeit lack of detailed concrete policies for the improvement thereof. Planned health workforce strategy (Ministry of Health 2010: 71) which is an indicator of the existence of right to health in a health system by Backman *et al* (2008) may contribute to improvement of quality in health care.

As of these four principles of right to health (availability, accessibility, acceptability, quality) there is a mixed picture in Turkey's current situation. A certain degree of achievement is absolutely extant in all areas; however it is far short of being perfect. Keeping in mind the principle of progressive realization using maximum of available resources, the reforms are expected to intend and succeed to make the situation better in terms of right to health. The wording of the reforms and stated intentions reflect a significant awareness of the right to health principles and requirements. This is absolutely a very positive aspect of the reforms in terms of right to health. However how these will reflect to the practical situation is a matter of concern especially for the critiques. How right to health-respecting provisions will be applied and be effective in people's lives will mostly be seen in time.

The peak point of the criticisms towards HTP unites on the idea that this is a liberalization/privatization/corporatization movement that will turn health into a commercial good. Hence state's resignation from health care provision, the autonomy that hospitals are going to get, and changes in this vein disturbs them. But how relevant are these fears and criticism in terms of right to health?

Firstly, the logic of "as much health care as your money can get" is absolutely contrary to the understanding of health as a human right. However, according to the CESCR, first hand provision of health care services is not a duty of the state. On the contrary, states have the margin of discretion to choose their systems and policies freely, as long as they protect the rights of their citizens from bad practices of third parties, and ensure the enjoyment of the right by everyone one way or the other. Public, private, or mixed health care provision and health insurance systems are all acceptable. (CESCR 2000) From this point of view, although one may share the concerns of the critiques related to the path of the HTP and possible consequences of it, in legal sense, privatizing health system does not constitute a problem, or a contradiction for human rights.

Carrying Caglar Keyder's (Keyder *et al* 2007) remarks on universality to the field of human rights, a bigger problem seems to exist in the method of financing health services.[32] Intrinsically, general health insurance system which depends on premiums; Bismarck system (as opposed to national health service system or Beveridge model which depends on taxes) is not very compatible with human rights. Because in the final analysis, people will have that right as long as they keep paying for it with their premiums. Being obliged to pay a price to be able to enjoy a right that one has for being a human being is highly contradictory, at least in the normative sense. So what the state ought to do against this human right of an individual, (not a citizenship right) is to provide him the required service whether he pays anything or not. Although in the

[32] For a study on classification of health systems, which includes the two types that are referred here see Roemer, Milton. I. 1991. *National Health Systems of the World Volume 1: The Countries.* New York: Oxford University Press.

national health service system people still have to pay their taxes, here there is no direct price-service relationship as in premiums. State gives everyone the same service and finances it from its general budget, which is created by the general taxes people have paid. So regardless of the amount of the money they have given, even if they have not paid any taxes at all, they will be eligible for the health service equal to everyone else. As health is a fundamental human right, in case that one evades tax state may go after him and duly punish him for that but cannot obstruct his utilization of the health services, i.e. enjoyment of his right to health. Plus, in the insurance systems children and unemployed women are protected only because the working father of the family is paying his premiums. Thus, no link can be set between the health care they are getting, and their human rights. However the children and women without an income hence not paying taxes are entitled to health care service as directly as the father and totally independent from him. So the human right aspect is much more clear and uncontroversial in this second system. Considering the huge amounts of finances that health systems require, depending only on state budget may not be feasible. However this paper is not a policy recommendation, and the evaluation above is a normative one trying to show the theoretical deficiency of the premium system in terms of human rights. Moreover, although a detailed analysis would be beyond the scope of this paper, mixed systems for financing health care is always possible.

4.4.2 Turkey and State Obligations in Right to Health

To what extent Turkey is fulfilling its obligations in right to health? Analysis below is made based on the requirements stated in the general comment no. 14.

4.4.2.1 Obligation to Respect

According to the obligation to respect, states' actions or decisions should not infringe people's rights or may hinder their enjoyment of the rights. For many elements of the obligation to respect in the general comment, Turkey has good grades. There is no state enforced discriminatory practices, or coercive treatments by the state, no limitation of access to contraceptives. As health is not only about the bodies of individuals but also about the environment they are living in, states must refrain from polluting land, water and air. It is debatable if Turkey is really respecting this or not. Ongoing initiatives of the state for nuclear power plants despite strong opposition from the people and environmentalists cause question marks about state's sensitivity on environmental risks. (Greenpeace 2010) Although there is no law directly limiting access to health care of some people, the geographical distribution of facilities and personnel constitutes an indirect problem. HTP explicitly aims to strengthen primary health care facilities and make access easier for everyone. This explicit commitment is an important starting point for improvement. However the family medicine system that constitutes the core of these efforts is subject to criticisms as discussed above. Although the new UHI system is an improvement from many aspects compared to the previous dispersed system, the details of the system is prone to cause inequity in the application. Similarly, as has been discussed before, the nature of the social insurance system puts certain groups in disadvantage compared to better-off segments of the society, which practically hinders equal access for all persons.

4.4.2.2 Obligation to Protect

In obligation to protect states need to take necessary measures to prevent third parties' violation or endangering of people's right to health. In ensuring equal access in health-related services given by third parties, the situation in Turkey is not problematic, except to a certain extent the financial aspect. Access to private health care facilities is practically impossible for the poor if the facility does not have a contract with the Social Security Institution. Even when it does have the contract, the required out-of-pocket contributions may cause inequality in access. However it must be noted that the state puts a ceiling to maximum contribution that a private facility may demand[33] and this can be considered as a measure in part of the state to prevent increasing inequalities in access. Moreover it should be noted as a development that unlike the former application where only government employees could benefit from their social insurance when using private health services, as part of the HTP everyone covered by the universal health insurance, except the green card holders can utilize these facilities. In the right to health framework, privatization is not outlawed but states should ensure that availability, accessibility, acceptability, and quality are not threatened. Although there are researches showing low patient satisfaction in private hospitals due to long waiting times and short consultation spans, (Caha 2007: 62) there is a certain standard in private health facilities in Turkey. To maintain these standards, there are regulations controlling the licensing standards, physical conditions and equipment

[33] According to the council of ministers decision in 2009 the ceiling price is 70% of the price decided by the The Commission for Pricing the Health Care Fees for that service. "Özel Hastane ile Vakıf Hastanelerinin Puanlandırılması Hakkında Duyuru" Accessed Online in SGK. Last Access: 02 November 2010
http://www.sgk.gov.tr/wps/wcm/connect/a205f880413896c8a29cbb4a37026f07/Ozel--Hastane_ile_Vakif_Universite_Hastanelerinin_Puanlandirilmasi_Hakkinda-Duyuru.pdf?MOD=AJPERES

requirements. Ministry of Health supervises private hospitals, policlinics and medical centres via provincial health directorates. (Yardim 2008: 142-43)

In ensuring certain education, skill and ethical code of conduct standards, state's efforts up to now were not enough to prevent criticisms such as the shortcomings in pre and post graduation medical education, quality and capacity of schools training other health personnel (Tekneci 2003), lack of supervision and planning for the new medical schools and related decrease in the ratio of well-trained physicians. (Savas 2003) HTP takes these criticisms seriously and tries to address such problems as one of the components of the programme aims for "knowledge and skills-equipped and highly motivated health human resources." (Yardim 2008: 276) Within this component, however the intended intervention to education in medical schools seems to be limited to an introduction of family medicine branch. It is also acknowledged that only a graduate degree does not guarantee qualified health care. The importance of on-going training of the professionals and regular certification of their eligibility is also accepted. (Yardim 2008: 284) Ministry of Health Strategic Plan targeting an adequate number of health personnel with higher competency standards and matching education schemes aims better educated health professionals be them physicians or others.

As another obligation states need to protect all vulnerable and marginalized groups. On this point, despite rhetorical commitments for more sensitivity for women, in the new system the previously existing positive-discriminations for women, such as a longer-term social protection are annulled. This seems to be a

retrogression in women’s health rights and controversial in terms of human rights. For children, the intended universal coverage for under-eighteens regardless of their families’ insurance situation is a big step forward in terms of providing better protection to them. For the very poor, by making the state pay their premiums, HTP will provide a more equitable health protection as compared to the previous green card system. (Green Card holders have not yet been included fully in the system. The intended date for their inclusion is 2012.) There will be no difference from person to person in terms of coverage in this new situation. Collecting everyone without any sort of hierarchical groupings such as Bağ-Kur, SSK or green card under one umbrella without discrimination is also formally more proper for human rights. However as previously discussed, it is very probable that who are considered to be better-off than the people eligible for the premium exemption but are actually on the edge of it will have very difficult times in using their right to health and achieving health care.

4.4.2.3 Obligation to Fulfil

States also have obligations that require a more active involvement from them. They need to sufficiently recognize the right to health in political and legal systems; which in the case of Turkey exists to a significant extent. There are national laws in this vein, which includes many points common in right to health approach, however as mentioned before, they are reluctant in using the term “right to health”. Turkey is also a party to many international conventions that recognizes the right to health. The way of litigation is also open to a certain extent, although the efficiency of it has not proved very strong up to now. Oyal

Case held in ECtHR, about a new-born infected AIDS during blood transfusions, constitutes a good example of the inadequacy of remedies in Turkish juridical system for deadly faults in the health system. The Court decides that the redress that is judged in the domestic proceedings had been "far from satisfactory" (ECtHR 2010) and sentenced Turkey to provide full medical cover for the child till the end of his life, along with compensations for pecuniary and non-pecuniary damages.[34] This inadequacy, according to ICESCR general comment, constitutes a violation by the state of the right to health of people.

On the points such as ensuring adequate access to underlying determinants of health, appropriate training for medical personnel, adequate number of health facilities, information on healthy life-styles, Turkey is absolutely capable of maintaining a certain average, and cannot be accused of being in complete violation of its obligations in this sense. However, keeping in mind the principle of "progressive realization with maximum of available resources," ("ICESCR" 1966, Art. 2) as an upper-middle income country with a certain level of development and social state tradition, more and more should be expected from Turkey. For example, the numbers related to hunger, shelter, or sanitation as given previously in this chapter shows how far Turkey currently is from the goal of "ensuring equal access for all to the underlying determinants of health" (CESCR 2000) –which is not half as bad in EU countries.- To be able to see and realize progressive realization having comprehensive disaggregate data and adequate monitoring systems is a must. At the moment

[34] Oyal v Turkey. ECtHR. App. No: 4864/05 (23.03.2010)

scholars conducting research are having difficulties in achieving necessary data as proper, detailed and updated as they need with the lack of regular, comprehensive nation-wide health surveys. (Erus and Aktakke 2011: 4; Yasar 2010: 21) The national health information system that is initiated with the HTP is a developing IT project that will contribute to monitoring. (Kose and Akpinar 2008)

There are more problematic obligations to fulfil. Implementing policies to eliminate environmental pollution is one of them. There is a strong environmentalist voice criticizing negligence, sometimes even deliberate actions of the state. Gold mining in Bergama is a very clear example proving such accusations right. In 1992 a company had been given a permit for operating a gold mine using the cyanide leaching process. As the detrimental effects on the environment and on health of cyanide and of other chemicals being released during the process is well known, the administrative court annulled this permit upon application of the residents of the region. This decision, which was also strengthened by a decision of the council of state, has not been implemented and the people of the town applied to ECHR in 1998. Meanwhile necessary permits have been given and the mining company kept its operation going despite the proven risks. The court in 2006 found a violation of article 6 (respect for private and family life) and article 8 (fair trial) of the Convention. (Dogan 2008) The ignorance of the state of people's rightful fears about the detrimental effects of this practice, and more importantly ignorance of various court decisions finding such fears applicable show how insincere and

insufficient Turkish state is in fulfilling the requirements of environmental protection.

States also need to have a concrete national policy and its effective implementation to maximize occupational safety. Although the constitutional provision regulating health does not make any reference to occupational safety in health, the Law of Obligations, the Labour Law and others regulates this issue. Even though the main responsible in ensuring workers' safety is the employer, it is accepted that state is also responsible in the implementation and supervision of the occupational safety provisions. (Zeytinoglu 2002: 146) In that respect, both the publicly high profile incidences such as the deaths of workers in mines or in dockyards, and occupational injury statistics[35] cause doubts on Turkish State's success in meeting its obligations to fulfil and protect.[36] This issue strongly attracts attention of the EU as health and safety at work is one of the titles in the accession process.

Finally states have an obligation to prepare a detailed national health policy and plan to realize the right to health. Turkey, especially the Ministry of Health seems to be doing the requirements of the obligation, at least since the HTP. Ministry of Health Strategic Plan 2010-2014, which is the first of such a plan

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[35] According to data of ILO, total rates of fatal injuries per 100.000 insured workers in Turkey was 20.5 in 2006. This rate is incomparably higher than other Europen countries. In the same year the figure is 7.2 for Bulgaria and 3.13 for Hungry. International Labour Organization, Last Access: 10 Novermber 2010. http://laborsta.ilo.org/STP/guest

[36] Limter-İş, a major labor union in harbour and dockyard sector, ascribes the main responsibility to the state, blaming it for the ineffectiveness in implementing the laws, insufficient and ineffective inspections of the work places, and insufficient sanctions and penalties for the wrong-doers. It also blames the state for the hard living and working conditions that practically obliges the workers to accept everything the employer demands. Tuzla Tersaneler Bölgesi İzleme ve İnceleme Komisyonu. 2007. "Tuzla Tersaneler Bölgesindeki Çalışma Koşulları ve Önlenebilir Seri İş Kazaları Hakkında Rapor" Last Access: 10 November 2010. http://www.limteris.com/haber/haber_detay.asp?haberID=4

replies to this need. It is seen that the strategic plan, although not a perfect one without flaws[37], is a very well-prepared, detailed and comprehensive study. It sets strategic goals and detailed, concrete, numerical, time-bound strategic targets. It indicates the responsible units, and the supervision and reporting procedures. All these are part of state obligations on right to health, so reflects a parallelism with a right to health approach. As to the content the situation is similar. First of all the definition of health that it embraces is a holistic one, rather then a narrow one, compatible with the definition right to health requires. It is stated that "the main goal of the activities of the Ministry of Health is to maintain health for everyone in a state of complete mental, physical, and social well-being." (Ministry of Health 2010: 41) It shares the right to health principles, such as increased quality, accessibility, effectiveness, efficiency, measurability and equity. (Ministry of Health 2010: 67) To ensure people's active participation in the decision-making processes on the issues that can affect their health[38], to improve effectiveness of supervision and inspection, to take measures to improve patient confidentiality, to adopt a human-oriented approach, to respect equity, to provide special protection for the vulnerable and the people in special need, to provide easier access to health care for them are among the goals of the Strategic Plan which reflects the right to health understanding. (Ministry of Health 2010)

[37] For example, some of the targets are pretty vague and does not provide any concrete ideas or methods; or some targets does not completely meet people's demands, such as the occupational health. It is also interesting that although it is repeated that the Turkish state in its constitution and other legislation recognizes health as a right, there is no call for respect for human rights in health care provision, but only a reference to patients' rights.

[38] The examples of Bergama gold mines and Akkuyu Nuclear Power Plant show that in practice state's attitude is not as hopeful as the rhetoric in official documents.

Health has been accepted both as a human right and a constitutional right in Turkey for a half century. In the last decade, especially since 2003, there is considerable effort for a transformation of the health system. Stated aim of this transformation is to achieve higher health standards and a better health system. Official documents; laws, programmes, strategies not only use a language that is more or less compatible with human rights, but they also reflect a compatibility with the methods and principles of thereof. The scene can be considered to be quite hopeful for the near future in this sense. However, high numbers of human rights violation complaints, and problems hidden in the details of the new legislation that may possibly reveal in the near future during implementation causes big question marks about the practice. Incompetency between the laws and the practice points to a lack of internalization of human rights in different levels of administration, and people giving health service. Ignorance by the state of the victimhood of certain vulnerable groups because of not-easily-seen details in the laws shows that respecting human rights is not a sincere concern even for the law-maker. The apparent sensitivity for human rights in official documents is not a reflection of a human rights consciousness of the society (including the doctors, hospital clerks, other personnel in health care, and to a less extent people receiving health care) but only a consequence of the global soft power of the concept of human rights, which occur in the form of a pressure on governments, including the Turkish government. Lack of a sincere, entrenched concern and respect for human rights in a society and its leaders is resulted with low levels of human rights enjoyment even in the presence of proper laws.

CHAPTER V

RIGHT TO HEALTH IN THE ACCESSION PROCESS

5.1 The Accession Process

In the examination of the place of the RTH as an ESR in EU-TR relations, the accession process will be in the spotlight. Accession to the EU is a process of harmonization and adaptation for any candidate or potential candidate state. Proximity of the applicant's fundamental values, administrative and economic systems to the members may make this route a process of little adjustments, or fundamental reforms. The path, components and benchmarks of the membership requirements are basically set forth as the accession criteria, and then elaborated for each candidate with Accession Partnership Documents and Progress Reports. This chapter will first look at the accession criteria and see if there is any role of ESR in EU's evaluation of candidates for the eligibility of membership. It will then turn more concretely to the example of Turkey, and look for ESR and RTH in accession documents. [39, 40]

[39] National Programmes are not included in the accession documents that are examined in detail. National Programmes are the documets that the candidate country prepares as a response to the Accession Partnership Documents, and give detailed plans of the candidate country for the required *acquis* alignment. Preliminary examination of the National Programmes in areas related to the health system, sych as the Social Policy and Employment chapters showed that they do not say much about the impact of EU in the RTH dimension of HTP. The exception to this is the non-

The roots of the accession criteria can be found in the founding treaties. After several amendments, these criteria which were initially in article 237 of the Treaty Establishing the European Economic Community which says that "any European State may apply to become a member of the Community,"[41] are now regulated in the article 49 of the TEU after the Lisbon amendments. Article 49 says that "Any European State which respects the values referred to in Article 2, and is committed to promoting them may apply to become a member of the Union."[42] In the Article 2, it is stated that "The Union is founded on the values of respect for human dignity, freedom, democracy, equality, the rule of law, and respect for human rights, including the rights of persons belonging to minorities. These values are common to the member states in a society in which pluralism, non-discrimination, tolerance, justice, solidarity, and equality between women and men prevail."[43] Among these enlisted common values, respect for human dignity and human rights are two points that one may expect a connection with ESR. UDHR, as stated in its preamble, has the idea of inherent dignity of human beings in its foundations and it is a basis for the enlisted human rights, including the ESR. Hence respect for human dignity requires from states to recognize people's ESR. The linkage between ESR and the requisition to respect for human rights is a more obvious one. As it has been

discrimination and gender equality-related directives of the Union that Turkey undertakes to entrench to national law. All these can be deduced from the National Programmes for the purposes of this thesis can be understood from the requirements Union brings about in the Accession Partnership Documents and Regular Progress Reports.

[40] Preliminary examination of the screening reports for Turkey showed that the information and evaluations in these reports do not help one understand the relation between health-related requirements of the EU and the RTH dimension of the Turkish health care reforms. Every element and aspect in the screening reports can also be found in the Regular Progress Reports with a detailed examination of the latter. So screening reports are not given place in this thesis.

[41] Treaty Establishing the European Economic Community as it is accepted in 1957

[42] TEU 2010 consolidated version

[43] TEU 2010 consolidated version

explained in Chapter II, EU has declared in various places its philosophical and legal commitment to all sorts of human rights, be them political, economic or social. Therefore reading articles 2 and 49 of the TEU together, one may rightfully expect that respect to ESR, including of course the right to health; and a commitment to promoting them would be a fundamental condition for membership.

The second document that regulated the accession criteria is the Copenhagen Presidency Conclusions, accepted at the end of June 1993 Copenhagen European Council. Three criteria set fourth in this document are accepted as the sine qua non conditions for membership since their acceptance. These are:

> "Stability of institutions guaranteeing democracy, the rule of law, human rights and respect for and protection of minorities,
> Existence of a functioning market economy as well as the capacity to cope with competitive pressure and market forces within the Union.
> Ability to take on the obligations of membership including adherence to the aims of political, economic, and monetary union." (p. 13)

Once again, what EU suggests with the term human rights is the key here, with the apparent inconsistency of what it declares to understand from human rights, and what it brings about and emphasize in practice.

Along with the Copenhagen Criteria, the implementation aspect is emphasized in 1995 Madrid Presidency Conclusions. Not only making the necessary legal adjustments, but also "creation of conditions for integration through the adjustment of administrative and institutional structures guaranteeing effective implementation of the *acquis*" (Europa Glossary) must be accomplished. "Almost as a fourth criterion" (Tulmets 2005: 658) after the three of the Copenhagen, this is also a part of the accession criteria for EU membership,

trying to make sure that the *acquis* is not only accepted, but also effectively implemented.

Although there is no direct reference in the accession criteria to ESR, there is strong indirect reference as they very strongly emphasize human rights both as a founding value of the Union common to all member states, and as a requisition for candidacy[44]. Remembering the previously explained attachment of the EU to the principle of indivisibility of rights, ESR must be as relevant here, as civil, political or cultural rights.

5.1.1 Accession Partnership Documents

In order to see if this is the case for Turkey an examination of the accession documents for Turkey need to be hold. The Accession Partnership Documents, which are prepared by the European Commission to provide the short and medium term priorities of the candidate countries for fulfilling the accession criteria, set forth objectives to be achieved for full membership and the financial assistance that EU will give for that. They are composed of short term and medium term priorities, both including sections of 'political criteria', 'economic criteria', and 'ability to assume the obligations of membership'. In the Accession Partnerships for Turkey, the importance of human rights can easily be felt, as it is supposed to be, in all four documents; 2001, 2003, 2006 and 2008. Political criteria, where human rights are handled, are given in the short term priorities in all documents except the first one. This is meaningful in terms of emphasizing the importance and urgency of enhancing the human

[44] The first of the Copenhagen Criteria is called the political criteria. An applicant state cannot be accepted as a candidate before it is considered by the Council and the Commission to be fulfilled these political criteria.

rights situation. As to the different groups of rights, CPR and ESR seem to be both considered. However, a dominance of CPR issues can be felt. When we look at the political criteria we see that in the first two documents there is no reference to ESR. While freedom of expression, freedom of association, freedom of assembly, freedom of thought, conscience, and religion, and fight against torture are all directly and explicitly listed, there is no social and economic right.

The only reference to the socio-economic situation we find in the political criteria sections in the 2001 and 2003 documents is about the regional disparities. It is stated that efforts should be intensified "in particular to improve the situation in the southeast, with a view to enhancing economic, social and cultural opportunities for all citizens." (2003) There is no doubt that there is a parallelism between "enhancing economic and social opportunities for all citizens" and the language of the human rights people: 'respecting, protecting and fulfilling ESR'. However this does not mean that these two expressions are the same. "Enhancing opportunities" not only lacks a rights language, but it is also much less ambitious than human rights talk should be. When we do not concentrate on the political criteria alone and look at the entire texts of the Accession Partnership Documents, we are able to find references to health, education and social protection. "Improvement of the general level of education and health" (2001: L85/19; 2003: L145/50) is one of the medium term objectives of economic criteria. Under social policy and employment title in 2003, there is the call for taking measures "to promote access to and quality of healthcare" (p. L145/53). These points give the signs of an acceptance for

the part of the EU, the inadequateness of the general education and health situation in Turkey. Improvement in these respects could be the greatest part in the effort to enhance right to education and right to health of individuals. However, the fact that they took part only in the economic criteria sections points to a market oriented, aggregate approach to these problems, rather then a primary concern of individuals' rights.

In the Accession Partnership Documents of 2006 and 2008, 'human rights' section under 'political criteria' is divided as 'civil and political', and 'economic, social and cultural rights'. So in these two documents we can see direct reference to ESR. Nevertheless, although we can find women's rights, children's rights, labour rights and non-discrimination under this title, other very basic ESR, such as the right to education, right to health, food, water, housing, or right to an adequate standard of living are not pronounced at all. Absence of these rights is the case for all four documents. Even tough education and health are considered, right to education and right to health are never referred to. As has been examined in the previous chapter, all these abovementioned rights are very relevant in the case of Turkey, and should not be extenuated as part of Turkey's human rights development efforts. The rights that are given in the documents are absolutely no less important. They are all urgently required for Turkey. But, in a comparison of ESR with other rights, a point that needs to be considered is that neither women's rights, nor children's rights or non-discrimination are peculiarly social and economic. They are all umbrella concepts that comprise different rights and issues, some of which are social and economic, but some of which are civil and political. So counting

only these rights in the ESR section, without any particular reference to other economic or social right in general, may be considered as giving this group a smaller place than the group of CPR.

5.1.1.1 Right to Health in Accession Partnership Documents

Accession Partnership documents do not ignore health. They make remarks on the need for better health statuses and to achieve that, better social security systems. However it is not easy to come to a straight forward conclusion about EU's philosophy in its approach to health. Does it have a rights-logic, or not? It is very important to note once again that the term right to health is not mentioned in any of the documents, not even for once. Health is not being referred as a fundamental right. As an indicator of that, neither the ESR sections, nor the political criteria sections do involve any reference to health. Women's rights, children's rights, or non-discrimination titles under ESR sections, do not make any points on the health-related aspects of these rights. Still, it would be misleading to conclude that the EU does not care about the right to health at all. Although there is no direct reference to health as a human right, certain points about health that the EU deliberates reflect sensitivity to the principles and elements of the RTH as set out in General Comment No. 14 of the CESCR especially after 2003. This dilemma demonstrates an inconsistency and confusion in part of the EU about the way it approaches to health. It also points to a change in EU's attitude after 2003, the year when Health Transformation Programme was initiated. As it will be examined later, the fact that the same change in 2003 exists also in progress reports, reinforces the attitude shift of EU after the initiation of Turkish reforms.

Apart from the fact that health is never referred as a right, or in the context of human rights in accession partnership documents, there are points showing a contrary tendency. One of the three main sections that talks about health is the 'Economic Criteria'. (The other two being the 'Consumer and Health Protection' and 'Social Policy and Employment') Handling health as a part of economics, gives clear signs of an approach to health from an economic point of view. In such a point of view, health of the people will only be important as an asset for a better functioning economy. Human beings are considered as gears of a system and their health is an issue of concern only for the sake of the system. This contradicts with the idea of human beings as ends in themselves, but contrarily treats them as means. In the same vein, they need to be healthy not because it is a fundamental right of them, but because their health is a means for a better functioning, more competitive economy. This is extremely unsuited to the framework of human rights.

In EU's call for the improvement of social protection with a financially sustainable and effective social security system[45] there is both an economic and a humanitarian dimension. It is important that effectiveness of the system is underlined, but there is not a clear indicator of the existence of a human rights emphasis here. Effectiveness of the social security system may well be underlined for the sake of a well-functioning economy rather then a concern for the human rights tied to it. In the 'Consumer and Health Protection' sections topics are determined in quite a narrow framework, limited to the areas of

[45] In 2001 and 2003 documents it is seen in Social Policy and Employment sections, (Name of this section was Employment and Social Affairs in 2001) in 2006 and 2008 documents it is seen in Economic Criteria sections.

tobacco use, blood, tissues and cells, mental health and market surveillance to maintain product safety. The problem with regard to human rights is hidden in the title. Uniting consumer protection and health in the same chapter points to a market-oriented approach that values human beings as consumers, and necessitates the protection of health of consumers rather then of human beings.

In medium term economic criteria sections, in all four documents, there is the call for the improvement of the general level of health paying particular attention to disadvantaged regions (Council of the EU 2001; 2003; 2006b) or women (Council of the EU 2008). This awareness of the low health status levels of Turkey (low compared to EU countries) and demand for its improvement is no doubt important. However, 'general level of health' signifies an aggregate approach rather then a right-based approach since improvement in the general level does not necessarily mean improvement for everyone. This shows that the issue of concern is not the individuals, as should be in a human rights understanding, but the averages. Hence 'improvement in the general level of health' is not an expression of the human rights-language and its use illustrates the lack of rights mentality. Contrarily, the emphasis on the attention that is needed to be given to disadvantaged regions and women is in line with human rights logic with its underlying values such as equity and extra attention for vulnerable groups. However, as it is under the section of 'Economic Criteria,' this makes one think that there is an economic logic behind, such as achieving more competitiveness. It is important to draw attention to a nuance here. While the wording in 2001 and 2003 documents are "to take measures for" and "to ensure" the improvement of the general level of

health, in 2006 and 2008 it changes to "continue to improve". This shows that EU acknowledges domestic efforts for the improvement of the health situation. Considering that after 2003 these efforts were an extension of the ongoing health system reforms, it may well be said that the reform process has not been gone unnoticed by the EU and has been reflected in the accession partnership documents. As another indicator of the same fact, although in 2001 and 2003 social policy and employment sections EU puts forward the requirement to embrace related *acquis* in the field of public health[46], in 2006 and 2008 this requirement disappears from the documents. Not only this statement disappears, but in 2006 and 2008 there is no mentioning health or social security, including a need for reform. All these again may be evaluated as an outcome of the domestic reform process and its appreciation by the EU. This evaluation will be strengthened when considered together with the trends in the progress reports in the next part.

As part of the controversy with the not-right-oriented approach to health-related issues, 2003 document in the Social Policy and Employment section (p. L145/52) expresses the requirement to "transpose EU legislation in the *field of public health* including (…) the fight against discrimination." Fight against discrimination in public health is absolutely crucial for the existence of right to health. EU's stress on this is important in that sense. However, there is a nuance here. It is difficult to say if non-discrimination is emphasized here as part of an ideal public health system; or health is only mentioned as one of the areas that non-discrimination should prevail. If the former is the case, non-

[46] Along with other fields, i.e. labour law, equality of treatement between women and men, occupational health and safety, and coordination of social security.

discrimination as a major principle of the right to health would indicate the existence of rights-approach to health. On the other hand, if the latter is true, it does not say much about right to health, but only indicates the importance of the principle of non-discrimination for the EU, which is already unquestionable. Nevertheless call for non-discrimination in the field of health is good for the existence of rights logic in this field. Right to health sensitivity can be felt more clearly in another sentence in the same section demanding from Turkey to "take measures to promote access to and quality of health care." (Council of the EU 2003 l45/53) Ensuring people's access to health and maintaining high quality health care standards are two core principles of the right to health as has been seen in the previous sections. Accentuation of these reflects human-oriented concerns detached from aggregate/average-oriented approaches, and is very much parallel to right to health principles. It needs to be underlined once again that this right to health harmony looms large in 2003; the year Turkish health and social security reforms are initiated.

Accession Partnerships are documents that list down the legislative and practical steps a candidate country should take. In the four Accession Partnership Documents that has been prepared up to date, health and social security systems are accepted as issues of concern, and certain demands have been put forward by the EU for improvements regarding these. Hence especially prior to the initiation of the domestic reforms, it is clear that EU finds areas of health and social security problematic and wants change. However, human rights dimension of this change is not equally clear as there is no visible right to health demand. The direction of the required health and

security system reforms are undetermined in terms of right to health. Instead there is an inconsistency in the ways health is approached which is reflected to the reader of the documents as a confusion, uncertainty, and indifference with respect to right to health.

5.1.2 Regular Progress Reports

Shifting the examination to Regular Progress Reports, which annually evaluates the progress Turkey has maintained in accession criteria, we see a slightly different situation. Progress Reports are extended documents that look at the actual conditions, assess the reforms and their outcomes, and state the need for further developments where necessary. As they are rooted in Copenhagen accession criteria they are composed of three parts; political criteria, including the human rights; economic criteria, and the ability to assume the obligations of membership. Different from the Accession Partnership Documents, in human rights sections of progress reports we can see some ESR more concretely. This is especially true for education. Education is handled in economic criteria too; as a part of human capital, but the primary place education related matters are dealt with are the human rights sections. Hence for the issue of education, EU's approach has both the sensitivity of a human rights based approach with the rights language, importance of individuals, transparency, accessibility, non-discrimination emphasis; and a concern for the societal, macro level impacts.

However this approach we encounter in education falls weak in convincing us about the adequacy of the attention given to ESR in general, because it does not continue for other rights of this group. The major section in the reports to look

for ESR is the 'Economic and Social Rights' sections under the 'Political Criteria'. Here, the subjects listed are: women's rights, including issues on violence, gender equality and non-discrimination in education and employment; children's rights in particular on education, child labour, and child poverty; workers' rights especially on trade unions and collective bargaining; socially vulnerable and disabled people; and internally displaced people. Once again, there is no direct reference to right to health, housing, food, water, or adequate standards of living.[47]

5.1.2.1 RTH in Regular Progress Reports

The places that health issues can be found are quite dispersed across the reports. As it is an issue that can easily be affected by factors directly or indirectly connected to health, various sections of the reports need to touch upon this issue. Economic Criteria, Political Criteria, Agriculture, Fisheries, Social Policy and Employment, Free Movement of Persons, Food Safety, Veterinary and Phytosanitary policy, Consumer Protection and Health, Judiciary and Fundamental Rights are only some of these very diverse sections that deals with health one way or other.

Similarly, the aspects of health that are examined or mentioned are also varied, among which there are health indicators of the society as an element of human capital, health services and social security criticisms and reform needs, consumer health protection, plant and animal health, health and safety at work, tobacco consumption, and minorities' access to health.

[47] These are all rights set forth in the International Covenant on Economic, Social and Cultural Rights, and in its general comments

Whether the Union's approach to health in the progress reports has a human rights orientation is a question that has to be asked to see the relation between the right to health logic in Turkey's health system and EU accession process. In such documents one may expect to see certain signs to reveal this human rights logic behind health. The most obvious sign would be the explicit acceptance of the right to health. Direct references to the term 'right to health' would take the reader half way of being convinced about the right approach. Even in the non-existence of the use of the term 'right to health', if there is a concern about health issues in the framework of human rights then these issues would be expected to be included in the human rights sections of the reports. As right to health is an ESR, in the reports where there is a separate heading for ESR, health should be examined there. These signs of the right to health understanding which are in the form, are not the only ones; and their existence is not sufficient. If the term right to health is used in the right place, but the content of the term is totally emptied out, this would not be a rights-based approach to health. Likewise even if the term is not used, the implicit existence of the main elements and principles of the right to health throughout the document may signify an important closeness to the appropriate approach to right to health. In this sense, evaluations of health in Turkey from the point of the main elements of the right to health as indicated in the General Comment No. 14, such as availability, accessibility or quality should be seen if the Union has a concern about health as a human right. The core principles of the right to health such as equity, non-discrimination or extra care to disadvantaged people should also be an issue of evaluations and demands of the EU for a sincere

right to health understanding. In the search for the right to health approach, one may also expect to find a broad definition of health, which includes not only bodily, but also social and environmental factors as required for right to health.

In examining the progress reports from the first one in 1998 till the last one in 2010, these signs as determined in the last paragraph will be sought. Their existence in EU's criticisms of Turkey's health system and demands for reforms will be evaluated together with the reform process in Turkey. The extent to which the waves of demands with a right-based approach in the progress reports corresponds to the right to health sensitive reforms in Turkey, will give the chance to assess the impact of the accession process on right to health in Turkey.

There is an interesting pattern in right to health appeal in the progress reports over the years, which is actually similar to the less obvious pattern in accession partnership documents. While there is hardly any explicit or implicit reference to health as a right in the reports until 2003, beginning from that year a gradual but still appreciable increase in right to health understanding can be felt. Knowing that 2003 is the year when last series of reforms in health and social security systems in Turkey are initiated, it may be said that the right to health touch in Turkey's reforms is not a direct consequence of EU pressure in that direction. However, EU does not ignore the right to health related developments that came with the reforms. On the contrary it adds right to health elements to its evaluations more enthusiastically and increases its demands in this vein after 2003.

5.1.2.1.1 Regular Progress Report 1998-2003

There is no physical existence of the right to health in the reports until 2003, as until then health is never mentioned in economic and social rights sections. The only places that there is a talk about health in protection of human rights sections in general, are the minority rights section in 2000 which refers to the backwardness of health in southeast Anatolia, and same section in 2002 which points to bad health conditions of internally displaced people. The one and only use of the word 'health' together with 'right' in all the reports including 2010, is where civil society movements in Turkey are appraised in the 2002 report. "A range of civil society development initiatives are also on going addressing issues as diverse as pluralism and cultural diversity to women's health rights." (European Commission 2002: 13) As seen this usage gives only hints of a right to health understanding in part of the EU, and does not really reflects such an understanding in its approach to health and health care in Turkey. Hence, it may confidently be said that the terms that are used, and the sections that health-related matters are handled do not point to a rights logic in reports until 2003.[48]

In reports of 1998, 1999, 2000, 2001 and 2002, very differently from the human-orientedness of the human rights approaches, there is a clear economic orientation in evaluations on health. Health status of the population and the health conditions they live in are accepted as an element of human capital in all

[48] In fact this lack of health issues in human rights sections except references to health conditions in prisons and of internally displaced people in a few reports continue until 2005.

these reports.[49] As part of the general evaluation of the economic criteria in 2000, just as an example of many similar sentences in all reports until 2003, it is stated that “the quality of education, health and infrastructure needs to be improved in order to enhance the competitiveness of Turkish human and physical capital.” (European Commission 2000: 31) Of course health has a place as an element of human capital in economic analysis, however not balancing this with other aspects of health which is less about macro economic impacts, but more about the impacts on individuals’ lives, shows a disconnection from health as a human right. When the only importance attached to health comes from its value as an economic asset, which improves competitiveness of an economy, health becomes a means rather than being good in itself for the individuals who have it. From a right to health dimension, the health systems should be as well-developed and the health status of the people should be as elevated as possible not for some benefit to be gained, but because this is the way it is supposed to be as it is a fundamental right of all human beings.

Economic orientation in the reports is also evident in the way that the social security and health systems in Turkey are criticized, and developments are evaluated. Inadequate funding, insufficient expenditure, inefficiency are the terms that dominates the criticisms, leaving much less space to quality, availability, accessibility, acceptability of the health services. So health is considered as a service that the state has to give, and evaluations are concentrated around the provision side of this service. However in a right to

[49] Under “Capacity to Cope with Competitive Pressure and Market Forces within the Union” sections except 1999 report.

health evaluation, the side of the receiver i.e. human beings taking the health care service should be the centre of attention. For example, EU praises the reforms of the period saying that "*the ongoing social security system reform* would result in the collection of more accurate information, increase the effectiveness *of* revenue collection, complete the legal framework for a privately funded pension system, and reform the health insurance scheme." (European Commission 2002: 93) Effectiveness of revenue collection, and privately funded pension system are both direct benefits for the state, rather then the individuals. The direction of the health insurance reform is not even mentioned, so its possible impact on citizens is not even taken as an issue of concern. So the receiving side is overlooked while it should have been the primary concern for the right to health. One of the important exceptions to this is the attention drawn to the bad status of health indicators in social policy and employment chapters of 1999, 2000 and 2002 reports. Although this carries an important humanitarian touch, the linkage with the right to health is still not so direct. As a more direct bound with the right to health, in 2000 it is stated that "decent standards of primary health care must be ensured for the whole of the population." (European Commission 2000: 50) However this statement which reflects an embracement of the principles of the right to health is really an exceptional case with no other similar example. Another statement with the human rights-touch is the requirement "to redefine priorities in a medium term perspective in order to provide sufficient level of investment in education, health, and social services." (European Commission 2000: 31; 2001: 45) However, despite the strong connection with ESR values, this is still a sentence from the economic evaluation parts, and thus has economic motives.

The progress reports of 1998-2005 embody the EU demands for social security and health system reforms. These demands do not have the human rights logic until 2003, beginning to pay more attention to humanitarian values after this date. In the reports after 2005, although criticisms continue in certain areas, these are not in the form of reform demands. However, between 1998 and 2005 the reform need is very clearly stated with expressions such as: "*the social security system* needs a thoroughgoing structural reform. Most health indicators are considered unsatisfactory given the country's level of socio-economic development, and its health service therefore needs to be significantly improved" in 1998 (p. 49); or "a reform of the public health care system is urgently needed" (2000: 49; 2001: 68) and "the reform of the Turkish social security system is an on-going process and urgently needed" in 2000 (p. 49) and 2001 (p. 69) or "Turkey should take the necessary measures to ensure financial stability of the social security system and effective co-ordination among the different social security institutions" in 2002 (p. 95). With these statements at hand, it is quite clear that there was a push from the EU for changes and improvements in social security and health systems in the period before the comprehensive social security system reform and the HTP. However the human rights or the right to health ingredient are demanded neither in the description of the reforms nor as part of the criticisms until 2003 when the reforms are already initiated.

5.1.2.1.2 Regular Progress Reports 2003-2011

The human rights stress in health and the implications of the right to health in the reports, if not the explicit use of the term, begins to be felt more and more after 2003, the year the HTP was initiated. More human oriented approaches rather than economic-oriented ones, more reference to health in the context of human rights, emphasis on equity and other right to health values are some of the signs of this important change in the general attitude of the reports.

In place of the economic and financial criticisms of the former period, in 2003 the health reform demand has a clear human focus. "…in the area of public health an efficient and effective allocation of available resources is needed to improve the health status of the population, levelling off the disparities of key health indicators according to regional, urban/rural and socio-economic characteristics." (European Commission 2003: 89) Concern for the improvement of the health status of the population along with a stress on balancing the disparities of all sorts is very parallel to the right to health approach requirements. In a similar example in 2004 (p. 112), "discrepancies in the health status of the population and inequitable access to health care" are given as the main problems in the area, and as such, a human rights-sensitive approach to public health is displayed. The same tendency continued in 2005, and "improved population coverage and equity of access in the field of health care, and *overcoming* the geographical disparities of care supply" (p. 96) are demanded with an unquestionable concern for right to health principles such as coverage, equity of access, and equitable distribution care supply. After the last social security and health system reforms, the reform demands decrease,

however the same human focus can still be seen in the assessment of the reforms. Equal benefits and liabilities for everyone, free healthcare for children under 18, special attention to the poorest are aspects that the EU expresses its appreciation in different reports. (European Commission 2006: 51; 2008: 21)

Another substantial change after 2003 is the gradually increasing appearance of health in the context of human rights, in parts of the reports on human rights including the ESR. The term 'right to health' is still not used; however dealing with the issue in human right segments itself reflects a suitable approach that considers health as a right. Moreover the aspects of health that are under consideration under such titles are all important elements of the right to health such as equity, accessibility, non-discrimination or attention to vulnerable groups. In 2003, the only reference to health in the protection of human rights is in the minority rights section about a concern for the access to health facilities of the internally displaced persons (IDP). In 2005, while attention is paid to mental health under economic and social rights, in minority rights, problems of the Roma population with "accessing adequate health" is taken into the agenda. This is repeated in 2006 with both reference to mental health in economic and social rights, and to Roma population in minority rights, pointing to the "discriminatory treatment *that Roma experience* in access to adequate health." (p. 22) Here, the underlying principles of the right to health; non-discrimination and adequate access are salient. Beginning from 2007, the place of health in ESR becomes strikingly more prominent, bringing an unavoidable right to health influence to health-related issues. In the ESR section of the 2007 report, health care for the disadvantaged segments of the society is taken into

consideration. The gap between men and women in health, unregistered children's and persons with disabilities' access to health are touched upon. In the minority rights "discriminatory treatment to Roma in access to adequate social protection and health" and the fact that "IDP in urban areas live in poverty with little or no access to social, educational and health services" (European Commission 2007: 23) are criticized. So both adequate and equitable access to health care for everyone without discrimination, and special attention for vulnerable groups of the society became essential elements of the issue of health in the progress reports by 2007. The same reference to the discrimination in health services that the Roma population faces is reiterated in 2008, 2009 and 2010 reports. Health in the context of women's rights is handled in 2008 and 2009, and handled in the context of children's rights in 2008 and 2010 reports, suitably to the ongoing trend. Same is true for the access to health of the people with disabilities (2008 and 2010) and of IDP (2008 and 2009). In 2009, as part of women's rights, the development in Turkish legislation concerning the "awareness raising activities and gender sensitivity training programmes for public service and health personnel" (p. 23) is praised, signifying the importance EU attaches to non-discrimination in health care. Emphasis on the "rights of the mentally ill patients, in particular to ensure that they are given the opportunity to consent to or refuse treatment, either personally or via a guardian" (p. 25) also reveals the human rights sensitivity in health for vulnerable groups.

As shown, after 2003, especially as from 2007, the right to health principles and elements dominates the way health-related issues are handled. Access to

health of Roma, IDP, unprotected children, women, and people with disabilities; non-discrimination in the contexts of Roma, people with disabilities, and women; equity in socio-economic, geographical and gender perspectives are all deliberated in almost all the reports. This emphasis on equity, one of the most important principles of the right to health, is very tangible both in and out of the human rights sections.

Another concrete indication of a right to health understanding is the reference the 2006 report makes to the Report on Human Rights Violation Claims of the Human Rights Presidency of the Prime Ministry. By pointing out that "the vast majority of applications *are* related to health and patient's rights, non-discrimination, right to property, and social security rights" (European Commission 2006: 12) the EU shows that it does not have an objection to the acceptance of health as a human right, of which violation by the state should be prevented.

The changing scope of the Consumer and Health Protection sections may also be evaluated as a change in the way health is handled. Until 2005, Consumer and Health Protection chapters were practically only about consumer health. They had nothing related directly to the health of the people as citizens or human beings, but cared only health of the consumers. So the coverage was limited to the impacts of agricultural or industrial goods on the health of the consumers, and related mechanisms such as market surveillance. However, beginning from 2005, the public health issues such as tobacco use or communicable diseases which had been examined under Employment and

Social Policy chapters since 2002 are taken to Consumer and Health Protection chapters, making the content of ‘health protection’ more about health of the people, rather then health of the consumers. This nuance, although may be overlooked, is an important one signifying a broader definition of health, which is closer to the right to health understanding. In addition to this, the content of ‘public health’ also widened in 2003 covering issues such as need for health status improvement, overcoming discrepancies and equity problems. (European Commission 2003; 2004; 2005)

In 2008, as a very important development for the right to health, socio-economic determinants of health are taken into consideration for the first time, although in a very brief and shallow fashion. Socio-economic determinants of health “are the conditions in which people are born, grow up, live, work and age. These conditions include a person’s opportunity to be healthy, his/her risk of illness and life expectancy.” (WHO Regional Office for Europe-b) They are strongly attached to the underlying determinants of health such as access to adequate food, sanitation, or housing as defined in the Right to Health General Comment. Existence of the underlying determinants of health are prerequisites for good levels of socio-economic determinants, but it is not sufficient as studies reveal that “even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than the rich.” (Marmot and Wilkinson 2003: 7) Hence, socio-economic determinants of health has a very close relationship with health equity, which is defined as “the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social

advantage/disadvantage." (Braveman and Gruskin 2003: 254) Concern for socio-economic determinants of health and concern for health equity mutually nourish each other, and both of their enhancement benefits the overall right to health situation. With these connections in mind, the fact that the EU talks about the socio-economic determinants of health is a very positive and promising sign for the entrenchment of right to health in EU-Turkey relations.

Another eye catching difference between the reports 1998-2003 and 2003-2010 is the place given to reform demands. Especially with the 2006 report, which is the year Law 5510 on Social Insurance and General Health Insurance was accepted for the first time and the application of the Law 5502 on the Social Security Institute was initiated, the remarks for the need of social security and health reforms left their place to the assessments of reforms and calls for implementation and enforcement. As an example among many other, 2006 reform acknowledges the ongoing reforms, praising especially the humanitarian dimension. "*With the social security reform of 2006* benefits-liabilities will be equal for everybody; free healthcare will be provided to all children under-18. The reform aims to ensure the long term financial stability of the social security system and regulate assistance to the poorest." (European Commission 2006: 51) Similarly 2008 report (ps. 21, 22, 63) assesses the progress achieved with the adoption of the Law on Social Insurance and General Health Insurance, and praises the new laws about their contribution to children's rights, persons with disabilities and vulnerable people. 2010 report accepts that "access to primary health services and extension of the general health insurance scheme have improved." (p. 71)

After 2003, namely after the initiation of the health and social security reform process, EU demands for enactment gradually leaves place to demands for enforcement. In 2004 and 2005 reports it is stated for the first time that "the main challenge in social policy is related to the full implementation and enforcement of the *acquis* on the ground." (European Commission 2004: 113; 2005: 97) In 2009, although progress in the area of health is acknowledged, "the institutional capacity necessary for legislative approximation and implementation in the field of public health is *considered* to be not fully in place." (European Commission 2009: 84) Similarly in 2010, "the administrative structures and enforcement powers necessary to implement the transposed legislation and monitor progress require strengthening." (European Commission 2010: 93)

This parallelism between domestic developments and progress reports does not prove a correlation between EU demands for amendments and Turkish reforms. On the contrary it may be argued that the recent reforms, i.e. HTP is an outcome of 30 years-long needs and discussions for health reform in Turkey, and they are not induced by the EU. (Yildirim and Yildirim 2008) Whether EU is the motive behind recent reforms or not is not substantially important for the purposes of this study. What is significant for this paper is the impact of accession process on the right to health dimension of the Turkish health care system after the last reforms. Even if it does not prove causality, it is a fact that EU's health-related demands in the progress reports decrease significantly following the domestic reforms. In these post-reform progress reports,

evaluations of the reforms are made and developments in the field have not been overlooked. This proves that be them EU-induced or not, HTP and related reforms responded to EU's criticisms in the pre-2003 progress reports and have been met with appreciation by the Union. What is interesting here is the place of the right to health logic in this fluctuation. In the same period, namely after 2003, another change in the progress reports is the gradual prominence that the right to health approach gains. It is important to remind once again that 2003 is the date that the HTP was initiated, and within the turmoil of social security and health systems of the following years (2006 being the peak) related reforms were realized. While health and human rights have almost never been considered in the same context in the pre-2003 reports, health becomes an essential part of human rights, and human rights become integral in health issues after this date. Human rights related aspects of social security and health systems finds places to themselves in the reports, either as criticisms for their inadequacy, or as appreciations for the developments came with the reforms. Recalling the human rights ingredient of the new laws in health in Turkey, one can drive the conclusion that although right to health approach in health was not a demand of the Union for accession, once they see the hints of such a respect to rights in health legislation of Turkey, they applause with appreciation. This shows that right to health elements and a rights-respecting health system are important values for the EU, even though they do not voice this as concrete demands. For some reason they do not ask for it, but once they see it, they do not hesitate to applause and ask for more.

The confused image that the EU displays as it talks about the values and principles of right to health on one side and not turning them into explicit requirements for candidates on the other side leaves states on their own in the way they perceive and interpret the european model. However this does not change the fact that there is a 'european social model' to imitate for every candidate country even though it may be a different one for each of them depending on their perceptions. Therefore even in the absence of direct EU requirements in social policy or in health, one can still talk about 'europeanization of social policy' and EU's indirect influence that creates it. According to Guillén and Palier (2004: 204), this indirect influence may function through soft legislation such as the recommendations or through 'cognitive europeanization.' "This is the notion that attitudes and perceptions about social issues and social problems, and the best way to tackle them are shaped informally through debates and discourses" (Manning 2007: 496) So even though the research in the accession documents has shown that there is no direct EU influence behind the right to health element of the HTP, this does not show that EU has no impact on it. On the contrary, it should be kept in mind that the accession process involves various multidimensional harmonization and cohesion routes, some being demanded and applied openly, some being realized in more subtle ways. However, considering that the right to health winds blowing in the HTP remains very superficial and insufficient in effecting people's actual enjoyment of their right to health, this indirect influence seems insufficient. It may be suggested that a more explicit, more concrete, more entrenched and systematic EU pressure for right to health in the health system could have an impact on better outcomes.

CHAPTER VI

CONCLUSION

Health is a human right of everyone for over 60 years. It is the right to the highest attainable standard of physical and mental health, which inevitably includes social and environmental well-being. As an internationally recognized legal norm, right to health creates a vertical right holder-duty bearer relationship between the state and its citizens. In this relationship, everyone without any sort of discrimination may demand services and conditions for the protection of their health. In return, state has the legal and normative obligation to meet these demands and using maximum of its available resources, progressively ensure full enjoyment of the right to health by everyone. Considering the unquestionable importance of health in people's lives and the strong linkages between the right to health and other human rights, the attention that is needed to be given to health as a human right is obvious.

Turkey no doubt has a functioning health system which may be quite effective compared to many underdeveloped and developing countries. However, right to health appropriateness is more then the existence of facilities and services. It

requires attachment and respect to certain principles both in laws and in practice. The importance given to health as a human right may be questioned even in the most affluent countries, as seen in the very problematic example of United States, or much more subtly in the EU. Right to health is a legal norm both for the EU and for Turkey as they have recognized it through charters, international covenants and constitutional provisions. In this sense, one may rightfully expect to see a full fledged attachment to this right in both sides. Considering the EU accession process that Turkey is in and the critical role of human rights in this route, right to health is supposed to be a momentous element in EU's expectations and demands from Turkey. Similarly, as a country which is striving to join the Union for over fifty years, Turkey should try to meet these demands.

This study revolved around two main areas; the place of right to health in the accession process and the role of the accession process for the right to health in Turkey. In this framework, the research question was "what is the role of the EU accession process for the right to health in Turkey in the post-reform period?" In order to answer this question, the paper examined the place of health in the EU and the relevance of right to health for EU health policies. Then it searched for the right to health both in the laws and practices in Turkey, giving a particular attention to the health and social security reforms ongoing since 2003. In the last part, the place of right to health in the accession documents was scrutinized with the aim of seeing the relationship between right to health in Turkey and EU demands. The shorthand answer to the research question is that a concrete push from the EU for a right to health

oriented health system in Turkey cannot be found in the accession documents. Therefore one cannot talk about the role of the accession process for the right to health in Turkey based on these documents. However, it is worth noting that this does not mean that the right to health winds in Turkey has nothing to do with the EU accession process as there are other more indirect and subtle mechanisms in this process. However the scope of this study is limited to the accession documents.

Trying to answer the research question, in the third chapter, it is shown that the Union expresses its attachment to the idea of indivisibility of rights on the ESR-CPR divide. Therefore, it explicitly accepts right to health as a fundamental human right equal to all other human rights. This acceptation is also seen in various binding and non-binding documents such as the 2000 Charter of Fundamental Rights. However, in Union policies which have a direct impact on practices, commitment to right to health becomes problematic. It is important that health-related policies represent an attachment to right to health principles. However, it hardly reflects a commitment to health as a human right because this is only valid at the community level. Based on the principle of subsidiarity, everything about states' health policies and health care systems are left entirely to member states. Hence the Union closes its eye to possible right to health violations within the member states, casting doubt on its sincere embracement of the right to health despite its rhetorical respect.

The fourth chapter showed that the core elements of right to health do exist in Turkey. No doubt that there is a functioning health system with all sorts of

health facilities, health personnel and preventive and curative health services. However, the principle of progressive realization to the maximum of available resources dictates Turkey to achieve a better score with respect to right to health as an upper-middle income country. In this context, the analysis of the ongoing reforms since 2003 shows that the concepts that are emphasized and the words that are used in the laws, Ministry of Health publications on the reforms, and 2010-14 Strategic Plan are all highly coherent with right to health. Almost all the elements that are required to exist in a right to health-respecting health system according to the right to health general comment and the study of Backman *et al,* do find a place to themselves. Suggestions for a better system are given, although it is debated if they will effectively serve the aimed purposes. However, in actual fact this scene in the legal and official documents is not fully reflected to the field.

The situation in practice with the health status indicators, level of people's satisfaction of health services and high numbers of right to health violation claims prove that the right to health sensitivity on paper is not turned into practical reality. As the reforms do not create a regular and comprehensive right to health monitoring and supervision system, it can be said that a sincere will and determination to put right to health at the center of the health system is actually lacking in the law makers. In addition to this, deeper thinking on the reforms raise concerns in different groups, especially the health professionals' organizations regarding possible negative impacts of the proposed reforms, despite the ostensible right to health sensitivity. It is strongly argued by the largest health NGOs and many scholars that the new system after the HTP is

prone to serious inequities. Especially the fact that the health care provision becomes more and more privatized will bring a market structure to health. This will turn patients into consumers and health into a commercial good which is to be purchased. This creates a situation which is highly incompatible with the spirit of the right to health. The precautions against possible inequities such as the state paying the premiums of persons who are unable to pay for themselves, may fall short of preventing rights violations for everyone. Similarly efforts to obviate the disadvantage of the persons with disabilities or people in rural areas also seem inadequate. The insensitivity of the law makers in environmental issues, unwillingness in using participatory methods in decision making, regulations being enacted despite strong oppositions from health personnel, which may effect their motivation, hence quality of care, also raise question marks about the sincerity of the human rights concern. These may be expected to negatively affect the right to health performance of the health system in the near future. All these problematic points that are revealed after a detailed scrutiny, and the well-founded fears about what the health system is going to turn into, prove that the right to health coherence on the paper is not a projection of sincere intentions to put right to health at the centre of health practice. It is more like make-up than plastic surgery for the right to health deficiencies.

In the fifth chapter, the analysis of EU accession documents for Turkey, especially the regular progress reports revealed an interesting pattern. Although health is never referred as a right, right to health principles and a rights language begins to be observed after 2003 report. The economic-oriented

importance that had been given to health before 2003 leaves its place to a more human-oriented approach that revolves around rights of individuals even if not directly the right to health. Nondiscrimination, equity, accessibility, population coverage, health of vulnerable groups such as IDP or Roma, children's health are all issues that are brought up in the human rights sections after 2003 in an increasing fashion. Another interesting change in the reports which coincides with these is the shift from reform demands to reform evaluations on the part of the EU. Although until 2003, EU was demanding urgent reforms in social security and health systems, after this date the reform demands left its place to remarks related to developments in Turkey. Implementation and enforcement requirements became more prominent than enactment. As 2003 is the year social security reforms and HTP are initiated, even though one cannot talk about causality with the data in hand, it may be affirmed that there is a correlation. Be them EU-induced or not, reforms have responded to the EU's criticisms and they are welcomed by the Union. In the pre-2003 reports the right to health dimension of the demanded health reforms has never made an issue by the EU. The fact that the human rights aspect began to be brought up by the EU in the post-reform progress reports is an interesting situation which shows that right to health sensitivity of the HTP has not come from EU pressure in the accession process. On the contrary, it seems like the fact that the right to health has found itself such a place in HTP, has stimulated EU to appreciate the developments that it has not even demanded. It even made them ask for more.

It is not surprising that the reform demands in the progress reports turn into acknowledgement and appreciation of the changes after the years HTP is initiated. However, the gradual yet striking change in EU's attitude towards right to health is harder to explain. Although the EU demands in health-related areas were not human rights-oriented before 2003, after 2003, namely after the initiation of HTP, human rights dimension of health prevails with demands, criticisms and praises in this vein. This shows that the EU does care about human rights values in health. However, just like it refrains from naming these values explicitly as 'right to health', it also refrains from putting these forth as concrete requirements for a candidate country. It begins to voice rights issues in the context of health, and push Turkey in that direction only after Turkey has already demonstrated an intention and effort to regard them. EU's evasion to use the term right to health and to put forth concrete demands for it may have more than one underlying reasons. First of all, the principle of subsidiarity, which requires that all the possible actions and decisions should be taken at the state level, is an obstacle in front of health as a human right. As health is an issue subject to the principle of subsidiarity, EU does not intervene in the design, organization or implementation of health systems of the member states. The concept of right to health, by its nature comes with certain dictates on the states, and this reveals as a contradiction with subsidiarity. Hence it may be argued that embracing right to health as such would damage the principle of subsidiarity as it would require a bigger pressure on and a closer monitoring of the member states by the Union in a highly domestic issue. However, keeping health within the borders of the countries is itself problematic from the point of view of the right to health. In an organization like EU, the existence of people

within the boundaries of a state who are unable to achieve fast, effective, good quality health care is an issue which cannot be left solely to the hands of that state when health is sincerely accepted as a human right.

Apart from subsidiarity, embracing health as a human right would increase moral and more importantly economic responsibility of states. Certain rules, thresholds, requirements, accountabilities come along with the right to health, which increase states' burden. It is not surprising that EU, as an entity of states, do not explicitly turn the right to health into a must for all the member and candidate countries. This of course is a contradiction for an organization which is known with the importance it gives to human rights. The best explanation for this contradiction lies at the distinction of civil and political, and ESR. The fact that none of the ESR are taken as seriously as CPR in the EU shows that right to health suffers from the same tendency of downgrading ESR as human rights. This is a point to be rightfully criticized considering EU's rhetorical attachment to the principle of indivisibility of human rights. Believed to be different from the CPR by nature being cost-dependent, vague and relative, ESR are not protected as real human rights as wholeheartedly as their civil and political counterparts.

In Turkey, while right to health has a favorable position on the paper after the HTP, problems in practice affect the service people are getting, the standards that they are living in, and the attitude that they are facing. The legal framework that is compatible with the right to health does not bring actual enjoyment of the right by the people. It is seen that the human rights sensitivity

which was extant -or shown to be so- in the law making process disappears when it comes to application, supervision or the process following a wrongdoing. This confirms that the idea of right to health is not understood and sincerely embraced by the people who are responsible for people's enjoyment of their rights. Even in laws and regulations that are harmonious with the right to health in general, such as the recent reform laws in Turkey, scrutiny of the details shows right losses. These are ignored both during and after the period the laws are drafted, and this ignorance is a committed one despite large oppositions from the NGOs. These two facts prove that the human rights-sensitivity is only a superficial one and is not internalized even by the law makers themselves. In this sense, it is obvious that there is a problem in getting the state officials, health professionals and the public learn and internalize right to health sincerely. Human rights consciousness in different levels of the administration, in different levels of the health sector, and in people as the right bearers is still an objective to be achieved in Turkey, and its absence seems to be lying at the heart of the current right to health problems. This fact is being overlooked as serious right to health and patient's right educations for everyone in the health sector is not a part of the health system regulations. Similarly regular monitoring of the right to health situation in practice as it is experienced by the people is also not proposed. Without these, it seems difficult to make everyone involved in the health system, from the law maker to the patient, be aware of the right to health with all its elements. EU's hesitation in explicitly using the term right to health and making a right to health coherent health system one of the concrete demands for membership, is wasting the potential leverage of the EU accession process. Consistent EU demands for the right to

health in a concrete framework and appropriate international monitoring could be a push for Turkey for a more right to health-coherent health system, health protection and health care practice.

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