Check for updates

Article

APMJ

Asian and Pacific Migration Journal
2019, Vol. 28(1) 75–96
© Scalabrini Migration Center 2019
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/0117196819832721
journals.sagepub.com/home/amj

The transformation of the primary health care system for Syrian refugees in Turkey

Ceren Ark Yıldırım
and Ayşegül Komsuoğlu
Istanbul University

İnanç Özekmekçi
Erciyes University

Abstract
This article analyzes Turkey's policy response to the health needs of Syrian refugees since 2011. The innovations in immigration health policy cannot be explained solely on the basis of factors exogenous to the health sector, such as the massive arrival of Syrian refugees, the gradual Europeanization of Turkish immigration policy or new funding from the European Union. They also display several stages of endogenous learning driven by a reassessment of problems and reevaluation of preferences by Turkish authorities. The paper aims to explain three successive stages of Turkey's organization of migrant health care services: a pre-institutionalization stage in which existing facilities were repurposed, the establishment of the first dedicated migrant health centers and promotion of partnerships with non-governmental organizations (NGOs), and finally the employment of Syrian medical professionals and the decreasing role of NGOs in migrant health centers following the impact of the 2016 European Facility for Refugees in Turkey.

Keywords
Syrian, migrant health care center, primary health care, Europeanization, policy change

Corresponding author:
Ceren Ark Yıldırım, Istanbul Universitesi Istanbul Üniversitesi, Merkez Kampüs, Siyasal Bilgiler Fakültesi, Siyaset Bilimi ve Kamu Yönetimi Bölümü Fatih, 34452 Turkey.
Email: ceren.yildirim@istanbul.edu.tr

Introduction

The massive displacement of population due to the Syrian civil war has led to numerous challenges for host countries, one of the most important of which is providing health care for refugees. Turkey had 3,607,563 registered Syrians under temporary protection status (TPS) as of 29 November 2018, of whom only 153,413 lived in temporary accommodation centers while the rest were spread out among Turkish cities.[1] The highest number of Syrians under TPS is hosted in four cities. Turkey's most crowded city of Istanbul hosted 558,548 Syrians, while border cities like Şanlıurfa, Hatay and Gaziantep hosted 456,754, 441,197 and 417,013 Syrians, respectively. Also, the number of Syrians exceeds 100,000 in Bursa, İzmir, Konya Adana, Mersin and Kilis. According to data as of November 2018, 54 percent of Syrians are males and 46 percent are females. Some 47 percent of the total Syrian population under protection status in Turkey are between 0 and 18 years old. People between 19 and 64 years old make up 51 percent of the total Syrian population. The largest categories are 0–4 years old (574,308) and 19–24 years old (544,587). Temporary protection status, which requires registration with Turkish authorities, enables registered individuals to access fundamental rights and entitlements, including health care, education, social assistance and translation. The impact of this situation on the Turkish health system has gone beyond emergency response to bring about far-reaching changes in the delivery of care. This paper analyzes the successive stages of Turkey's organization of primary health care services for Syrians under Temporary Protection. We note that the Turkish government has shifted from expecting migrants to adapt to the primary health care system designed for the native population to putting in place a system explicitly aimed at, and largely staffed by Syrians themselves, but is also moving to reassert control of the refugee health system by reducing the role of non-government organizations (NGOs).

How and why this was done are the principal puzzles examined in this article. Simply positing a most effective functional response to exogenous shock, we observe, is inadequate to understanding what was done. In other words, "problem pressure" (Rothgang et al., 2010) alone does not explain outcomes. Most importantly, it fails to account for the observation that several different solutions were put forward in a relatively brief period. Invoking "policy learning" to analyze these changes is helpful but insufficient. We seek, at each step, to understand what was learned and why. To do this requires us to reorganize our observations systematically by considering chronological as well as analytical criteria. The first of these involves looking beyond the immediate crisis to consider two elements of pre-existing context:

[1]For all statistics please see: http://www.goc.gov.tr/icerik6/temporary-protection_915_1024_4748_icerik

the reform of the domestic health care system and Turkey's relations with the European Union (EU), including the overall impact of accession negotiations on migration policy, and the result of the 2016 accord on the management of displaced persons from Syria.

From an analytical standpoint, it will be important to distinguish, at each step, between the influence of conditions and decisions endogenous to the health sector and the impact of exogenous conditions and events. The evolving response to an ongoing problem, we suggest, depends both on how it is framed endogenously and on the exogenous context in which it occurs, neither of which is adequately captured by simple models of policy response or policy learning. This paper examines how Turkey has regulated primary health care services provided for Syrians under TPS living in its territory and whether the policy changes in migrant health are a result of modification of actors' values and preferences.

The review of policies was supplemented by primary data based on interviews with 17 key informants conducted between August and November 2017 in Istanbul and Ankara. The key informants included officials or representatives from the following organizations: Ministry of Health in Ankara ($n = 1$) and in Istanbul ($n = 2$), Council of Higher Education ($n = 1$) and Disaster and Emergency Management ($n = 3$). Other informants included the staff of the EU Delegation ($n = 1$), NGO representatives ($n = 6$), Syrian medical professionals ($n = 3$) and migrant health service clients ($n = 3$, three health services demanders), who are themselves under Temporary Protected Status, a category that is explained in detail later. The interviews were conducted mostly in the interviewees' offices. In the discussion later, their names are not revealed to protect their privacy.

Consideration of policy change revolves around two perspectives, that is between incremental approaches (Crouch and Farrell, 2004; Hacker, 2004; Streeck and Thelen, 2005; Clegg, 2007) and those that focus on critical conjunctures and exogenous shocks (Pierson, 2004; Thornton and Ocasio, 1999; Dobbin and Dowd, 2000; Schneiberg, 2005). In our analysis of this case, we seek to go beyond this somewhat artificial distinction to integrate various elements of change, as well as by paying close attention to matters of timing and sequence (Tilly, 1984). Approaching the question in this way allows us, in the first instance, to distinguish the endogenous evolution of the Turkish health care system, on the one hand, and events exogenous to it, on the other. The most obvious of these, of course, is the massive arrival of persons displaced by the war in Syria and the resulting strain on the Turkish health care system, but two additional factors also proved to be critical. These are the ongoing Europeanization of Turkish immigration law predating the Syrian crisis, and the increasingly urgent desire by EU member states to prevent uncontrolled movement of displaced persons into their territory. The latter led to the 2016 EU Facility for Refugees in Turkey, which committed to

provide up to six billion euros (EUR) to Turkey to support policies, programs and services for refugees in the country, particularly those focusing on humanitarian assistance, education, health, municipal infrastructure and socio-economic support.[2] Through January 2019, the EU's documentation attests to spending at least EUR1.94 billion; the remaining will be paid in the course of the implementation of facility projects until mid-2021.[3]

Together, these can be seen as elements of ''Europeanization'' in the sense of ''shaping of politics (and governance) in the domestic arena in ways that reflect policies, practices or preferences advanced through the EU system of governance'' (Bache and Jordan, 2006: 30). From the perspective of the Turkish state, the exogeneity of this dynamic is at best partial—Europeanization involves, among other things, the creation of common frameworks that rationalize and legitimize official action (Costello, 2006). This concept emphasizes both the need to understand the nature and the force of a particular EU instrument and how this fits with and is mediated by domestic circumstances (Bache, 2010). The perspective of this article, however, is not that of the state as a whole but specifically of the refugee health care sector. In this context, agreements relating to immigration in general and Syrians in particular remain exogenous. The health policy system was not their primary focus. Europeanization, in this context, can be seen as an external development to which the health system has had to adjust.

It does not follow, however, that the changes in health policy should be seen exclusively as responses to exogenous shock. A review of policies from 2011 through 2017 reveals internal or endogenous changes as well. The timing of policy innovations suggests that these cannot be explained solely on the basis of the exogenous factors cited above. To understand them, we must also allow a role for endogenous policy learning, what Radaelli (2003) refers to as differences between ''thin'' and ''thick'' learning. The former refers to the readjustment of actors' strategies to allow them to achieve the same goals in a new context or ''how to get around an obstacle by using a menu of well-known responses in various ingenious ways'' (Radaelli, 2003: 38). On the other hand, ''thick learning'' involves a modification of actors' values and thus a reshaping of their preferences and goals. We argue throughout this article that successive changes in migrant health policy are the result of ''thick learning,'' and that this in turn can best be understood through an analysis of the interaction between exogenous forces acting on the health system and the ongoing endogenous evolution of that same system.

In support of this hypothesis, we begin with a brief description of the previous reforms that have reshaped the Turkish health system. We then

[2]For details, please see https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/frit_factsheet.pdf
[3]For details, please see https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/frit_factsheet.pdf

summarize an important exogenous development predating the Syrian crisis: the gradual alignment of the Turkish system of immigration law to European standards. Having established these two critical elements of the context, we turn to successive responses to the health care aspects of the Syrian refugee crisis. The latter analysis shows how policy response moved from a largely ''passive approach'' to an ''active change.'' The change characterizes the shift from the expectation that migrants would adapt to health systems designed for the native population combined with the tacit acceptance of providing health care to refugees through an informal health care system to the formalization of a distinct health care system for displaced persons that takes their needs into account. This approach provides a window to understand the evolution of the framing of the health care question from an urgent, temporary humanitarian crisis toward the medium-term management of the health needs of a specific population (Schön and Rein, 1995). This article argues that the integration of endogenous ''thick learning'' with the exogenous pressures faced by health sector decision-makers shaped the fundamental reframing of the health care policies concerning Syrian refugees in Turkey.

Endogenous and exogenous background conditions

Two major reforms in Turkish public policy were underway prior to the Syrian refugee crisis. These reforms—the reform of the health insurance system and amendment of the laws and policies on immigration and asylum—proved to be extremely significant in defining the conditions in which refugee health policy would evolve.

Reform of the Turkish health sector

Following recognition in the 1961 Constitution of the right to health for all citizens, Turkey's health care system was organized along occupational status. It was based on three public insurance schemes—the Social Insurance Institution (*Sosyal Sigortalar Kurumu* or SSK) for formal workers, the Retirement Fund for Civil Servants (*Emekli Sandigi* or ES) and the Pension Fund for the Self-Employed (*Esnaf, Sanatkarlar ve Diger Bagımsız Olanlar Sigortalar Kurumu* or BAĞ-KUR)—that combined retirement pensions with health insurance. In this model, the government did not contribute to the financing, which instead came from employees' and employers' contributions. However, this system failed to provide universal coverage because of the high level of informal employment. In order to solve the coverage problem, the green card (*Yeşil Kart*) system was introduced in 1990 to provide free health care services for the poor.

A major transformation of this system was introduced by the Justice and Development Party government that came to power in 2002. Begun in 2003,

this reform was implemented in 2008, creating a compulsory general health insurance model covering all Turkish citizens. The previous stratified system for different occupational groups was abolished and all citizens were required to contribute to the public health insurance fund regardless of their employment status. All public hospitals owned by social security funds were transferred to the Ministry of Health. The private sector role in health delivery increased as the Social Security Fund started to purchase the services from private sector hospitals. By centralizing authority, this reform reinforced the position of the Ministry of Health through its roles in planning and supervising and also constructing the policy (Aktel et al., 2013). Other influential actors include parliamentarians, ministries and municipalities. In addition to these direct participants, interest groups, such as the Turkish Doctors' Association, Turkish Pharmacy Association and Turkish Dentists' Association, remain influential, as do associations such as the Red Crescent and Green Crescent, and international stakeholders, such as the World Health Organization, United Nations, World Bank, International Labor Organization and the Organisation for Economic Co-operation and Development, as external stakeholders.[4]

The 2008 reform also created changes in the primary health care system. Renamed the Primary Healthcare Services: Family Medicine Model, its purpose is to facilitate access to health care services and improve individuals' quality of life, and to ease the burden of secondary health care. To this end, family physicians recognized as clinic directors can employ health care staff directly, or can buy the services from outside. At least 1,000 and at most 4,000 people can register with a family physician. Family physicians are contracted workers. Family physicians are paid on the principle of capitation, according to the number of people who are registered to them.[5] A family physician is required to work with at least one more staff such as nurse, midwife and others.[6] While all citizens have the right to choose their physician, those who live in rural areas often have limited choice in practice and doctors have the right to choose patients as well (Öztek, 2009: 8–9). The family health clinics, with modifications discussed below, provided the model for clinics established for Syrian refugees after 2017.

[4]Ministry of Health, Strategic Plan (2013–2017), available at: http://dosyasb.saglik.gov.tr/Eklenti/9843,saglik-bakaligi-stratejik-plan–2013-2017pdf.pdf

[5]For details, please see the full text of the Family Physicians Law. Available at: http://www.mevzuat.gov.tr/MevzuatMetin/1.5.5258.pdf

[6]For details, please see: Regulation on family physicians' practice. Available at: http://www.mevzuat.gov.tr/Metin.Aspx?MevzuatKod=7.5.17051&MevzuatIliski=0&sourceXmlSearch=aile%20he

Europeanization of Turkish immigration policy

A second critical background condition—this one is exogenous to the health sector—is the more general evolution of Turkish law and policies dealing with foreign persons on its territory since the early 2000s. Closely tied to the ongoing accession negotiations between Turkey and the EU, but predating the beginning of the Syrian War, this development can be seen as an initially independent dynamic of Europeanization (Aydın and Kirisçi, 2013).

While European influence in the reforms of Turkey's immigration policies goes back at least to the 1990s (Tolay, 2012), a useful starting point are the measures adopted in the early 2000s with the explicit, and ultimately successful, aim of restarting accession negotiations. These include the 2003 law on work permits for foreign nationals and measures dealing with human trafficking and cross-border crime. Further movement was outlined in the *2003 National Program for the Adoption of the EU Acquis Communautaires*, which was followed by the *2005 National Action Plan for Adoption of the EU Acquis in the Field of Asylum and Immigration*. The latter, in particular, set out an explicit roadmap for bringing Turkish migration policy into line with that of the EU.

Implementing the principles contained in the National Action Plan took almost a decade, resulting in the Law on Foreigners and International Protection (LFIP), which came into force in 2014.[7] The first Turkish law to explicitly deal with the question of asylum, it established the General Directorate for Migration Management, within the Ministry of Interior. The term "refugees" is limited, under the law, to persons fleeing from "events occurring in Europe," following from the decision of the Turkish government to adopt this more restrictive version of the text of 1951 Geneva Convention on the Status of Refugees. Others can be considered under several additional "conditional" or "temporary" statuses. Of these, "temporary protection status" or TPS is the most directly relevant to the present situation. A similar status, which was applied by the EU in the 1990s to persons displaced from conflicts in the former Yugoslavia, was included in Turkish migration policy with LFIP in 2014 in the context of Turkish harmonization with EU migration policy. It "may be provided to foreigners, who were forced to leave their countries and are unable to return to the countries they left and have arrived at or crossed the borders of Turkey in a mass influx seeking immediate and temporary protection." The TPS is the only status that can be applied collectively to a group of persons displaced suddenly due to hardship in the origin countries, such as war, natural disasters and others. Thus, the TPS can be accorded in conditions in which individual assessment of asylum application cannot be carried out. This status created advantages for people fleeing from a

[7]For the English version, please see: http://www.goc.gov.tr/files/files/YUKK_I%CC%87NGI%CC%87LI%CC%87ZCE_BASKI(1)(1).pdf

crisis, since there is no waiting at the borders of a potential host country. Members of groups granted TPS can be included in the Turkish social welfare system and have a right to work. However, this status has disadvantages as well. The continuity of the status is not clear and it does not give any right to permanent residence.

The scope and benefits of Turkey's TPS were expanded and made more explicit by the Regulation on Temporary Protection issued in October 2014, which granted access to a broad set of rights, including health and social assistance (İçduygu and Millet, 2016: 4). The Ministry of Health was identified as the lead agency, and provision was made for the establishment of new health care centers.[8] The same regulation states that health services will be provided free of charge to Syrians under TPS, with the cost to be borne by the Disaster and Emergency Management Presidency (AFAD). This regulation also established a standardized procedure to allow Syrians to register for TPS by filling out a form prepared by the General Directorate for Migration Management. For persons lacking an identity card, biometric data, such as fingerprints and photos, are collected, allowing the production of a temporary identity card. Unregistered Syrians or those whose registration proceedings are not complete can have health services "in emergency situations and when they are crossing the border for the first time" (2014 Regulation on Temporary Protection, article 27).

By the time these laws and regulations were enacted, the Syrian crisis was well underway, and it was evident that TPS would be applied primarily to this population. It is important to bear in mind, nevertheless, that this was possible only as the outcome of a decade-long process whose starting point had nothing to do with Syria but was bound up instead in Turkey's ongoing accession negotiations with the EU.

Reframing the migrant health care problem: Toward an active approach

The recognition of the legal rights of Syrians under TPS (hereafter, "Syrians") to health care provides a critical precondition for receiving care, but does not specify either the type of care or how it would be delivered. In this section, we discuss two successive policy approaches prior to the Turkey–EU agreement of 2016. These represent the starting point for the initial conception and then a first reframing of the overall problem.

Pre-institutionalization stage

Following intensified conflict in the Syrian civil war, the first inflow of Syrian refugees began arriving in April 2011. Turkey's initial response was an open

[8]Please see: http://www.goc.gov.tr/files/files/03052014_6883.pdf

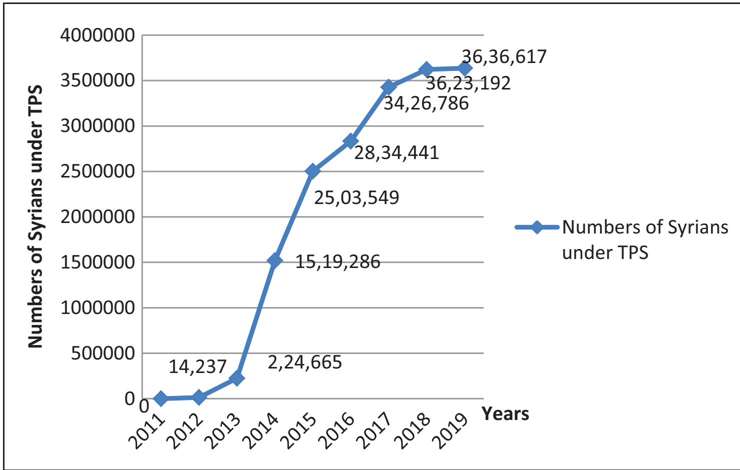

Figure 1. Number of Syrians under TPS* between 2011 and 2019.
TPS: Temporary Protection Status
Source: Turkish Ministry of Interior, Directorate General of Migration Management, http://www.goc.gov.tr/icerik6/gecicikoruma_363_378_4713_icerik, Data provided for 2019 were collected on 24.01.2019 as reported by the Directorate General of Migration Management.

door policy that allowed Syrians to cross its border unimpeded even if they lacked any identity documents. The number of the Syrians hosted in the camps near the border reached 7,000 in July 2011 (Ferris et al., 2013). Syrians fleeing the civil war were initially defined as ''guests,'' which is not a legal status under either Turkish or international law. As of October 2011, Syrians were granted TPS, but it remained unclear what this meant in practice in the absence of any explicit regulation in national legislation. Clarification came only with the LFIP and Regulation on Temporary Protection issued in October 2014 discussed in the earlier section.

The period from 2011 to 2013 can thus be considered as a pre-institutionalization stage for health provision. In April 2011, health care services became available for Syrians initially in Hatay province. These were determined through quickly decided regulations, dispensed through pre-existing structures, and limited largely to urgent care services delivered in the camps and along the border. As befits the framing of the situation as a temporary humanitarian crisis, AFAD was the main coordinator of these services. The rapid increase in the number of refugees after the first inflow in 2011 (Figure 1) and the accommodation of refugees overflowing the camps were the basic challenges to be met. Whereas the first migrants to arrive were predominantly men, a second wave of migration starting in 2012 was composed mainly of children and women, with distinct health care needs. As the number of

migrants increased, contagious diseases and similar risks to public health also became a primary concern in the media.

The growth of the Syrian population and accommodation outside the refugee camps brought about the regulation of health care services. With a circular issued on 18 January 2013, AFAD initially cleared the way for Syrians to benefit from the hospitals and health care centers free of charge. The expenses related to preventive and medical care for out-of-camps Syrians would be compensated by AFAD on the condition that the Syrians apply to the health care institutions in 10 cities where temporary accommodation centers were founded.

The central role played by AFAD underscores the initial identification of the problem as ''temporary.'' The situation was framed first and foremost as a humanitarian crisis, with needs and responses not so different from those associated with a major earthquake or other natural disasters. This limited approach was expanded in September 2013 due to the fact that Syrians increasingly were distributed in cities throughout Turkey. Hence, Syrians, on the condition that they have a temporary protection identity card and an application, were entitled by AFAD to receive free-of-charge health care services all over Turkey. This provisional measure was made permanent by the October 2014 Regulation on Temporary Protection.

Turkey's initial response to the Syrian health problem represents a clear example of thin learning, ''by using a menu of well-known responses in various ingenious ways'' (Radaelli, 2003: 38). The inherent limits of this approach, however, were soon reached. A first problem was overall system capacity. A primary health care system already strained and under-staffed was not capable of taking on the sudden surge in additional demand. The limits of the primary health care system also raised the burden on the hospitals.

The impact of dealing with increasing number of Syrians was felt throughout the system. Waiting times for both primary and secondary health care services in the districts with a high Syrian population became a frequent topic of media discussion. In 2015, the UN Regional, Refugee and Resilience Plan reported a 30–40 percent additional patient load in polyclinics and hospitals in the Southeast provinces. The existing capacities of primary and secondary health care facilities in Turkey proved insufficient to deal with this increased demand. According to the Action Document of the EU Trust Fund, the average number of hospital beds per 10,000 persons was planned to be at 10–13 beds in Turkey. However, after the mass influx of Syrians, this decreased to 6–9 beds per 10,000 persons in several provinces. In the provinces with a high density of Syrians, the ratio can reach up to 34,100 people per physician. In addition to the low number of physicians per capita, the number of visits to primary health care services for Syrians, at least in the camp (i.e., 3–5 visits per

patient per year) was higher than that of Turkish citizens (i.e., 2–3 visits per patient per year) (European Commission, 2017: 3).

Initial public research suggests that Turkish citizens accepted the concessions provided for the Syrians in the field of health care as long as this situation did not increase taxes (Kalaycıoğlu and Çarkoğlu, 2012). Accordingly, the assistance to the Syrians did not generate immediate political pressure on decision-makers. Turkish citizens did, however, expect priority in receiving health care services, and this caused disorder in the hospitals, contributing to a public sense of tension and an increasing tendency to identify Syrian refugees as "other" (Ekmekçi, 2017).

Compounding the problems linked to capacity were the language barrier faced by Syrians and the unavailability of patients' medical records. These communication difficulties also had negative effects on the health staff. Doctors providing primary health care services did not feel they could effectively attend to the needs of migrants (Aygün et al., 2016).

Migrant health centers and partnerships with NGOs

Policy responses in the first period were premised on the need to respond to an acute but short-lived crisis. A second period can be identified with a gradual change in problem framing to take into account the possibility that the situation was likely to last for a considerable time, as well as recognition of dysfunctions in the initial response. Two specific practices were developed as a result. The first was the establishment of migrant health centers. A second was the promotion of "inter-sectoral partnerships" to improve the quality of services and facilitate change. Turkey sought to collaborate with NGOs in order to ease the primary health care burden of Syrians. It also sought participation by Syrian health workers in the rollout of a primary care strategy.

A more systematic and coordinated health service for Syrians was defined by the "Administration Circular on Health Benefits for Temporary Protection Beneficiaries" issued in March 2015. This circular, most importantly, regulated the activities of the various actors providing health services (public institutions, NGOs, charitable institutions), and designates the beneficiaries of the health service. This circular stresses that registered Syrians are entitled to receive all health services mentioned in the Health Budget Law as well as emergency health services, preventive and protective measures. The Syrians not registered for TPS are entitled only to protective health services, emergency health services and treatment for infectious disease posing a threat to the public health.

A subsequent directive issued in September 2015 allowed primary health care services to be delivered by migrant health centers established as an additional unit of existing public health centers in areas of dense Syrian

population.[9] These were modeled on the family health centers established after the 2008 reform, but with some important differences. Each migrant health center was to serve 4,000–7,000 Syrians. Primary care health services continued to be provided by existing public health centers and family health centers in the regions with less dense Syrian populations.[10] First-stage diagnosis, medical treatment and rehabilitation services, vaccination and other protective health services, reproductive health services, monitoring services with respect to the sex and age groups and medical screening (pregnancy, new parents, newborn infant, infant and child, etc.) services and health education (hygiene, breast milk, healthy nutrition) services were provided in these recently established centers by Turkish doctors. A translator with suitable qualifications was employed in each center to ease the health service delivery and overcome the language barrier. Despite this, problems linked to language and culture were not entirely overcome. In some cases, patient records were mistranslated, producing more confusion.[11]

One solution was to incorporate Syrian health professionals into the staff of Turkish migrant health centers. To this end, the World Health Organization (WHO), in collaboration with Turkey's Ministry of Health, Yıldırım Beyazıt University in Ankara, the Provincial Health Directorate of Gaziantep and Gaziantep University, provided training courses for Syrian doctors in order to familiarize them with Turkish health services and practices. The course curriculum, developed by faculty members of Gaziantep University, was based on modern family practice scientific literature and the Ministry of Health's family physician training, as well as field visits to a family health center. The course included over 30 lectures and pre- and post-training tests, as well as a list of approximately 200 essential drugs for the main diseases encountered in primary health care. Materials were translated into Arabic, and generic and common Turkish names for medicines provided to facilitate prescription. The first training took place in November 2014. In the year that followed, a total of 201 Syrian doctors and 104 nurses and midwives were certified. Employment options for the persons certified through this program remained extremely limited, however. They could provide medical services for Syrians only in clinics operated by NGOs or in refugee camps (WHO, 2014).

This can be seen as a first example of ''thick learning,'' in which the nature of the policy problem was re-conceptualized through the acceptance of Syrian refugees as a longer-term problem, the social and infrastructural burden

[9]Migrant health centers established under the control and supervision of Public Health Centers, issued in the Official Gazette on 05.02.2015, No: 29258 based on The Regulation on the Public Health Center and Related Units.
[10]http://www.thsm.gov.tr/upload/files/G__men%20Sa_l___%20Merkezleri-Birimleri%20(1).pdf
[11]Interview with a Syrian doctor, Fatih District (Istanbul), 11.08.2017

of which could not be adequately addressed through the existing structure. This change represented a step further toward an ''active approach'' (Bollini, 1992) in which the health care system for Syrians was adapted to immigrants' needs.

In addition to the centers described above, the October 2015 directive opened the way for health services to be provided by NGOs. Two models emerged for clinics of this type. In the first instance, major international NGOs received funding from the EU and other international sources and, in turn, invested these funds in health service provided to Syrians in cooperation with Turkish NGOs. In addition, NGOs informed Turkish citizens about the financial, cultural and structural conditions of the Syrians by means of research, workshops, reports and brochures. A second type of clinic was run by Syrians whose associations were registered as NGOs in the Turkish legal system. Such clinics, run by various associations with different political orientations, played an important role in providing health services. Although not formally licensed, these clinics were tolerated by the state as a useful instrument to ease the burden on the existing health system. Based on the authors' field observations, these clinics charged low fees, as low as 20 Turkish Lira, although the laws and regulations cited above specified that care for Syrians should be free of charge. The socio-economic status of the patient may change the amount of fees or result in non-admission. While 40–45 percent of the fee was transferred to the doctor, the rest was retained by the NGOs.

Following the October 2015 directive, associations attempted to formalize primary health care provision. According to this regulation, associations seeking to provide voluntary health services for Syrians under TPS could do so for six months on the condition that they were approved by the Ministry of Health. At the end of this term, the license was to be renewed by local health authorities. Part of the flexibility provided to these centers was their ability to employ staff without a Turkish work permit, provided that they applied with their diplomas to local health authorities and worked under the supervision of those eligible to work in Turkey. Only Syrians could receive primary health care service from these facilities, and all treatment expenses including medicines and supplies within the scope of this service were compensated by the foundation or association concerned. By law, if not always in practice, services offered by these centers were free to users. According to this directive, the associations were not allowed to provide secondary health care services. However, NGOs have been able to circumvent this by employing Syrian medical personnel. For instance, Doctors Worldwide provided health care service to Syrians by service procurement from Bezmialem Hospital (called *Fatih* clinic) until August 2017, with funding from the EU and the support of the International Organization for Migration.

In the end, however, the partnership with NGOs was not retained as a model for the future. Although the 2015 directive has never formally been

revoked, it was in practice valid only until 2016. Only 17 clinics established by associations gained official status for six months, and, of these, none were renewed. Although unlicensed, these clinics continued to be tolerated, largely due to the inadequate capacity of the official system. In addition to providing care for Syrians who would otherwise have lacked it altogether, an additional purpose of this tolerance may be to limit possible opposition by Turkish patients who otherwise would share the same health care unit with Syrians. Although the NGO clinics are not formalized, their administrators reported in interviews that their activities have been monitored by the Ministry of Health. Even so, these clinics have produced various kinds of problems in the Turkish health system. It has proven difficult to identify their criteria for employment and to ensure that all staff is qualified. What's more, the way NGOs provide health service conflicts with that of official facilities. Even though the interviewees mention the audit period, NGOs provide services in conditions that cannot be easily supervised.

The impact of the European facility on refugees in Turkey

The most recent source of exogenous influence on the transformation of primary health care policy for Syrians in Turkey is the January 2016 EU Facility for Refugees in Turkey (hereafter EU Facility), which was the result of an agreement between Turkey and the EU to manage the flow of displaced persons from Syria into Europe. This agreement is expected to increase European aid to Turkey for the management of refugees by an order of magnitude: from the beginning of the crisis in 2011 till 2016, the EU has provided aid of EUR365 million to Turkey (European Parliament, 2016) in order to deal with the refugee flow; projected aid under the EU Facility is EUR3 billion, with the EU to provide EUR1 billion from its own budget and the 28 EU governments adding an additional EUR2 billion (European Parliament, 2016). The agreement included the possibility of an additional EUR3 billion after 2018. As of December 2017, the EU Facility had contracted for 72 projects worth over EUR2.75 billion.[12] These projects focus on six priority area: humanitarian assistance, migration management, education, health, municipal infrastructure and socio-economic support.

The assistance provided under the EU Facility is conditional to compliance by Turkey with the EU–Turkey Joint Action Plan on migration, which was enacted on 29 November 2015 and confirmed on 18 March 2016 with the ''one in one out deal'' (İçduygu and Millet, 2016) aimed at ending irregular migration from Turkey to the EU. Under this plan, Turkey is to take back all new

[12]DG-NEAR, ''Facility for Refugees in Turkey. Available at: https://ec.europa.eu/neighbourhood-enlargement/news_corner/migration_en

irregular migrants arriving in Greece through Turkey as of 20 March 2016. For every Syrian who is sent back from Greece, one registered Syrian in Turkey is to be resettled to the EU according UN vulnerability criteria.[13] In return, European countries agreed to establish the EUR3 billion EU Facility, as well as opening a new chapter 17 (economic and monetary policy) in Turkey's EU accession process and ensure the full implementation of the Readmission Agreement and the visa liberalization dialog previously agreed.

The EU Facility was established as a coordination mechanism for greatly increased financing using existing instruments. One such was the Instrument for Pre-accession Assistance (IPA). Use of this instrument, despite the fact that accession negotiations more generally had come to a political standstill, is largely a testimony to administrative expedience. It was easier to repurpose an existing instrument than to create a new one. Assistance was managed by the European Commission's Directorate General for European Civil Protection and Humanitarian Aid Operations (DG-ECHO). The 2016 agreement, thus, was fundamentally about migration; neither Turkish EU accession nor health care was its principal concern. As noted at the outset of this article, the 2016 EU Facility should be seen as exogenous with respect to the health sector. Even so, the EU Facility has contributed to the ongoing transformation of migrant health centers both by providing additional resources and by bringing these more closely into the scope of EU practice and regulation.

Two initiatives coordinated by the Facility for Refugees have been particularly important in changing the structure of the migrant health centers. The first is the EU-funded health project titled "Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities" (hereafter, according to its Turkish acronym, SIHHAT), which began in January 2016 for 36 months.[14] A second is the WHO-supported migrant health training centers for Syrian health workers providing adaptation courses into the Turkish health system. The Ministry of Health is the executive unit for both of these projects, which have three primary goals:

1. to provide culturally appropriate health care service to Syrians patients under TPS;
2. to support the Ministry of Health in its effort to provide adequate access to emergency, preventive, primary and secondary health care to Syrians; and
3. to integrate skilled Syrians into the Turkish health system through SIHHAT and the projects run by local health authorities and funded by WHO.

The total amount of the EU grant for migrant health care centers to be transferred to the Ministry of Health is EUR300 million. By the terms of the

[13]https://www.consilium.europa.eu/en/press/press-releases/2016/03/18/eu-turkey-statement/
[14]Action Information Factsheet, EU Facility for Refugees in Turkey, 05.05.2017.

grant, this can pay for medical operating expenses of the centers, but not for renovation or building costs. The SIHHAT project is to be implemented throughout Turkey but predominantly in Şanlıurfa, İstanbul, Hatay, Gaziantep, Adana, Mersin, Kilis, Bursa, Mardin, İzmir, Osmaniye, Kahramanmaraş and Adıyaman. It provides resources for establishing 790 migrant health units grouped in 178 migrant health centers. One unit consists of one Syrian doctor and one Syrian nurse to treat Syrian patients under the supervision of the Ministry of Health's Provincial Public Health Directorates. It is expected that 500–900 patients per day will be treated in these centers, which are designed around a ratio of 4,000 patients per doctor.[15] As of September 2017, two such centers had opened, in Kilis (89 percent of population is Syrians under temporary protection) and Ankara (1.6 percent of the population is Syrians under temporary protection). Of these migrant health centers, 42 are to have ''enhanced'' status. These will be established in regions with more than 20,000 Syrians to provide specialized services, such as internal medicine, pediatrics, obstetrics and gynecology, dentistry and X-rays. The aim of the enhanced migrant health centers is to ease the burden on hospitals and to raise the level of services to European standards.[16] The plan is to establish one such enhanced migrant health center for every 2,000 Syrians. As of May 2018, the number of centers reached 152.[17]

In addition to the health centers, 26 mobile health units and five cancer screening units will be in service. Moreover, 10 community mental health centers are planned in nine cities. Vitamin and mineral supplements will be provided to 270,000 infants and expectant mothers, and 6,255,000 doses of vaccines will be supplied. In addition, medical devices, equipment and furnishing for the 115 secondary healthcare facilities and the intensive healthcare capacity of 20 secondary healthcare premises have been increased in cities most affected by the influx of Syrian refugees.[18]

The integration of 1,500[19] Syrian health professionals is a defining feature of the new migrant health centers. Training and certification of personnel are thus central aspects of the program. In a project lasting from March to December 2017, DG-ECHO provided EUR10 million seed funding to WHO to open seven migrant health training centers in Gaziantep, İstanbul, İzmir, Şanlıurfa, Mersin, Hatay and Ankara. Under this contract, training for

[15]Interview with a key informant, EU Delegation in Turkey, Ankara, 6.10.2017.
[16]Interview with a key informant, Migration Health Department (Ministry of Health), Ankara, 21.08.2017.
[17]http://www.iha.com.tr/kayseri-haberleri/turkiyenin-152nci-gocmen-sagligi-merkezi-kayseride-acildi-2024283/
[18]Developments can be followed on various web-sites of the Ministry. For example, see: https://khgmsaglikhizmetleridb.saglik.gov.tr/TR,43240/gecici-koruma-altindaki-suriyelilerin-saglik-statusunun-ve-turkiye-cumhuriyeti-tarafindan-sunulan-ilgili-hizmetlerin-gelistirilmesi-projesiquot-sihhat-projesi.html
[19]https://www.avrupa.info.tr/en/project/improving-health-status-syrian-population-under-temporary-protection-and-related-services

750 Syrian doctors and 750 Syrian nurses will be started. In addition, 300 translators will be trained to provide Turkish–Arabic translation, primarily in hospitals (European Commission, 2017). The link between this initiative and the training program offered by the WHO between 2014 and in 2016, discussed above, is clear. The scope of the new program, however, is significantly greater. Certified Syrian health workers can now be employed in the migrant health centers established under the Ministry's authority.

These training programs consist of one week of theoretical and six weeks of practical education for Syrian doctors, midwives and nurses in WHO-supported training clinics where the national association works in cooperation with the Association for Solidarity with Asylum Seekers and Migrants (ASAM)[20] centers in Mersin, Ankara, Hatay and İzmir, and Doctors Worldwide (YYD)[21] centers in İstanbul, Gaziantep and Urfa. During the education process, carried out by Turkish physicians, the professional competence and performance of the Syrian health staff can be monitored. Successful Syrian doctors and nurses receive professional competence certificates from the Ministry of Health, which are sent to the Ministry of Labor allowing them to become registered workers. Health professionals are employed in the migrant health centers and work as one-year contracted personnel. So as to provide continuity in employment afterwards, a B1 level certificate in Turkish language is required after one year. On the date the interviews were conducted, 440 Syrian health staff had begun work, and 960 hospital referral personnel (translators) had been trained.[22]

Along with this practical program came legal changes. In January 2016, the Regulation on Work Permit for Refugees under Temporary Protection took effect, allowing Syrian health professionals to apply to the Labor Ministry for work permits six months after their registration under TPS. This law allows Syrian health professionals to enter the workforce in the Turkish health system, with the aim of both integrating Syrian professionals into the health system and also ensuring that Syrian refugees can receive health care without encountering language or cultural barriers. Legislation allowing Syrian health professionals to be employed was formalized by the Regulation Regarding the Change of the Regulation Regarding the Working Methods and Principles in Private Healthcare Facilities of Turkey for the Foreigner Health Professionals

[20]The Association for Solidarity with Asylum Seekers and Migrants (SGDD-ASAM) was established in 1995 in Ankara as an independent, impartial and non-profit association to assist refugees and asylum-seekers living in Turkey. SGDD-ASAM has been providing social and legal support to promote the rights refugees and asylum-seekers and their access to services. It offers psychosocial support and organizes numerous courses and activities to integrate them into social life. Since its establishment, it carries out its activities in more than 60 offices across more than 40 provinces in Turkey. See http://en.sgdd.info/?page_id=1276

[21]For more information on YYD, see: https://www.yyd.org.tr/tarihce/

[22]Interview with a key informant, Migration Health Department (Ministry of Health), Ankara, 21.08.2017.

of 1 April 2017. According to this, Syrian health professionals are exempted from the conditions in the regulation published on 22 February 2012, which eliminated the legal barriers only for foreigners possessing equivalent certificates or diplomas officially registered by the Ministry. Syrian health professionals certified under this program are eligible to work only in migrant health centers providing service to Syrians.

By the end of 2017, the Ministry of Health plans to close all the clinics operated by NGOs. The primary health care services that were allowed for a period of time will no longer be allowed to operate after 2018 January. NGO centers meeting the criteria will be transformed into migrant health centers. Health services are to be provided directly by NGOs only in two fields: mental health and psycho-social support, and physical therapy and rehabilitation.

Certain other migrant health centers do not fall entirely into the scope of the SIHHAT Project. These include a cooperative project of the UN Population Fund and the Ministry of Health: ''Women and Girls Safe Space.'' This project aims to provide reproductive health and family planning services and supplies (e.g., contraceptives and hygiene kits), including maternal health and psycho-social support related to gender-based violence. The initial target was to reach 41 ''safe spaces'' by the end of 2017.[23] According to the UNFPA's web site, as of the start of 2019, there were 30 such centers operating in various provinces in Turkey, of which five are incorporated into the larger migrant health centers active in 2019.[24]

Discussion and conclusion: Endogenous and exogenous elements of change

From the perspective of the Turkish health system, the Syrian crisis and the ongoing negotiations between Turkey and the EU on migration constituted exogenous events which called for action. With the influx of large numbers of Syrians to Turkey, they were granted the right to health care. While these external events created a need for action, they did not by themselves dictate specific policy outcomes. Cooperative and hospitable policy responses by Turkish health authorities to various aspects of the Europeanization of Turkey's migration policy and to the Syrian crisis were shaped by several stages of endogenous learning.

Initially, the problem was seen mostly as temporary with the expectation that Syrians would soon return home. Without changing any policy goal,

[23]UNFPA Turkey News (2017) Women and girls safe space is officially opened, 18 October. Available at: http://turkey.unfpa.org/en/news/devte?ti-women-and-girls-safe-space-officially-opened-18-october-2017-şanlıurfa
See related news at: https://turkey.unfpa.org/tr/news/%E2%80%9Cherkesin-%C5%9Fiddet-ve-ayr%C4%B1mc%C4%B1l%C4%B1ktan-uzak-ya%C5%9Famaya-ve-%C3%BCreme-sa%C4%9Fl%C4%B1%C4%9F%C4%B1-hizmetlerine-eri%C5%9Fim-hakk%C4%B1

[24]http://www.unfpahumtr.org/tr/merkezlerimiz?word=göçmen+sağlığı&city=0¢er_type=1

policy-makers addressed the Syrian health problem ''by using a menu of well-known responses in various ingenious ways'' (Radaelli, 2003: 38). A second period can be identified with a gradual change in problem framing to take into account the possibility that the situation was likely to last for a considerably longer time, as well as the recognition of the public burden of the initial response. In order to overcome this problem at the primary health care level, migrant health centers and the ''inter-sectoral partnerships'' with NGOs in the design and delivery of health services were established. These improved the quality of services, facilitated change for Syrian patients and health workers in TPS and eased the primary health care burden of Syrians on the Turkish health system.

A third period, beginning in 2016, was characterized by further ''thick learning,'' in which the nature of the policy problem was re-conceptualized through repeated interactions between the EU and Turkey. Central to this ''thick learning'' was a reframing of the problem from one of short-term humanitarian emergency to a longer-term question of service provision. In this context, it became appropriate to look once again to the Turkish system of family health centers for a model. The lessons of the first phase, however, suggested that simply incorporating Syrians into the existing system was not the answer. This led ultimately to a solution in which the existing system was adapted to the new situation. Beyond the obvious role of Syrian health professionals, there are additional important differences between migrant health centers and family health centers in administration, expenses and employment.

This repurposing and adapting of the existing model marked the shift from a ''passive approach'' (Bollini, 1992) that combined the expectation that migrants would adapt to health systems designed for the native population with toleration of informal health care provision for immigrants to a more ''active approach'' (Bollini, 1992), in which the formalization of a distinct health care system for displaced persons allowed adaptation of health services to immigrants' needs. This ''active approach'' also helped the Ministry to reassert control in the migrant health field by phasing out clinics operated autonomously by NGOs. A challenge for the future is whether this dynamic of thick learning can address the problems that will likely emerge as unintended consequences of the programs that have been put in place. Several elements suggest that the system will continue to evolve, even in the absence of further exogenous shocks to it. Two problems would seem to be of particular importance. The first is the issue of quality of services, which is presently managed through the establishment of state-supervised migrant health centers and the integration of Syrian doctors into the Turkish health system. This may allow Syrian health professionals to be socialized and trained in the norms, values and practices of the Turkish health system. The second issue is the ambiguity of the temporary professional competence certificates issued by the Ministry

of Health. This certificate does not equate to diploma equivalence. Professional competence certificates are provided within a scope of a program; no certificate of equivalence is provided for the integration of the Syrian health staff into the Turkish system. The temporary professional competence certificate introduced as a remedy to the short-term problems may produce a problem in the long term with respect to the employment policies of Turkey.

Our analysis of this case leads us to the conclusion that the thick learning (Radaelli, 2003) has led not only to a change in policy but to a reframing (Schön and Rein, 1995) of the underlying problems that must be tackled by policy solutions. Along with this has been an attempt to reassert control over health policy-making, whose long-term outcome cannot be fully ascertained. The integration of Syrian health workers into the refugees' health care system marked an important change in the implementation of migrant health policy by adding a new type of actor to the system. The inclusion of 1,500 Syrian health professionals and 300 additional translators as of 2019 will help to overcome cultural and language problems that affected the work of the previous migrant health care system. Moreover, these additional personnel will also address the lack of health care workers. However, the efficiency of these policy initiatives requires further research. A better understanding of the day-to-day functioning of migrant health centers and the professional legitimacy of Syrian health workers in the eyes of Turkish health workers would be interesting issues to be examined by future research.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this paper.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

Aktel M, Altan Y, Kerman U and Eke E (2013) Türkiye'de Sağlık Politikalarının Dönüşümü: Programı: Sağlık Bakanlığı'nın Taşra Örgütlenmesi Üzerinden Bir Analiz. *Sosyal Bilimler Dergisi* 15(2): 33–62.

Aydın U and Kirişçi K (2013) With or without the EU: Europeanization of asylum and competition policies in Turkey. *South European Society and Politics* 18(3): 375–395.

Aygün O, Gökdemir O, Bulut U, et al. (2016) Bir Toplum Sağlığı Merkezi Örneğinde Sığınmacı ve Mültecilere Verilen Birinci Basamak Sağlık Hizmetlerinin Değerlendirilmesi. *TJFM&PC* 10(1): 6–12.

Bache I (2010) Europeanization and multi-level governance: EU cohesion policy and pre-accession aid in Southeast Europe. *Southeast European and Black Sea Studies* 10(1): 1–12.

Bache I and Jordan A (2006) Europeanization and domestic change. In: Bache I and Jordan A (eds) *The Europeanization of British politics*. Basingstoke: Palgrave Macmillan, pp.17–36.
Bollini P (1992) Health policies for immigrant populations in the 1990s. A comparative study in seven receiving countries. *International Migration* 30(1): 103–119.
Costello C (2006) Administrative governance and the Europeanization of asylum and immigration policy. In: Hofmann CH and Türk A (eds) *EU Administrative Governance*. Cheltenham, Northampton: Edward Elgar, pp.287–340.
Crouch C and Farrell H (2004) Breaking the path of institutional development? Alternatives to the new determinism. *Rationality and Society* 16(1): 5–43.
Clegg D (2007) Continental drift: On unemployment policy change in Bismarckian welfare states. *Social Policy and Administration* 41(6): 597–617.
Dobbin F and Dowd TJ (2000) The market that anti-trust built: Public policy, private coercion, and railroad acquisitions, 1825–1922. *American Sociological Review* 65(5): 631–657.
Ekmekçi PE (2017) Syrian refugees, health and migration legislation in Turkey. *Immigrant Minority Health* 19(16): 1434–1441.
European Commission, Directorate General for Neighborhood and Enlargement (2017) Action document for EU Trust Fund. Available at: https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/eutf_madad_action_document_turkey_health_30062017.pdf
European Parliament, Directorate General for Internal Policies (2016) Turkey: How the pre-accession funds have been spent, managed, controlled, and the monitoring system? Available at: http://www.europarl.europa.eu/studies
Ferris E, Kirişçi K and Shaikh S (2013) *Syrian Crisis: Massive Displacement, Dire Needs and a Shortage of Solutions*. Washington, DC: Foreign Policy at Brookings.
Hacker JS (2004) Privatizing risks without privatizing the welfare state: The hidden politics of social policy retrenchment in the United States. *American Political Science Review* 92(2): 243–260.
İçduygu A and Millet E (2016) Syrian refugees in Turkey: Insecure lives in an environment of pseudo-integration. Working-paper, Istanbul Policy Center, Sabancı University, Istanbul.
Kalaycıoğlu E and Çarkoğlu A (2012) Türkiye’de Sağlık Toplumsal Bir Değerlendirme [Health in Turkey: A sociological analysis]. İstanbul: Koç Üniversitesi, Sabancı Üniversitesi.
Öztek Z (2009) Türkiye’de sağlıkta dönüşüm programı ve aile hekimliği. *Hacettepe Tıp Dergisi* 40(1): 6–12.
Pierson P (2004) *Politics in Time: History, Institutions and Social Analysis*. Princeton, NJ: Princeton University Press.
Radaelli C (2003) The Europeanization of public policy. In: Featherstone K and Radaelli C (eds) *The politics of Europeanization*. Oxford: Oxford University Press, pp.27–56.
Rothgang H, Cacace M, Grimmeisen S, et al. (2010) *The State and Health Care. Comparing OECD Countries*. London: Palgrave Macmillan.
Schön M and Rein D (1995) *Frame Reflections*. New York: Basic Books.
Schneiberg M (2005) Combining new institutionalisms: Explaining institutional change in American property insurance. *Sociological Forum* 20(1): 93–137.

Streeck W and Thelen KA (2005) Introduction: Institutional change in advanced capitalist economies. In: Streeck W and Thelen KA (eds) *Beyond Continuity: Institutional Change in Advanced Political Economies*. New York, NY: Oxford University Press, pp.1–39.

Tilly C (1984) *Big Structures, Large Processes, Huge Comparisons*. New York: Russell Sage Foundation.

Thornton PH and Ocasio W (1999) Institutional logics and the historical contingency of power in organizations: Executive succession in the higher education publishing industry 1958–1990. *American Journal of Sociology* 105(3): 801–843.

Tolay J (2012) Turkey's ''critical Europeanization'': Evidence from Turkey's immigration policies. In: Paçacı Elitok S and Straubhaar T (eds) *Turkey, Migration and the EU: Potentials, Challenges and Opportunities*. Hamburg: Hamburg University Press, pp.39–61.

World Health Organization (WHO) (2014) Training Syrian doctors in Turkey. Available at: http://www.euro.who.int/en/countries/turkey/news/news/2014/12/training-syrian-doctors-in-turkey-to-boost-health-services.