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Full Length Research Paper

The Evolution of the Concept of Health Services

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The provision of health services is the answer to the question of the kind of society we want in the future. The concept of health services, which is as old as human history itself, has changed over time depending on social dynamics. Previously, the only way to deal with disease was to let patients die. Demand for health care services began when this idea was replaced by the healing of patients. However, there was no organised provision of health care services until the industrial revolution. Health services gained the status of public goods due to the development of medical technology and the devastating effects of wars. Then, the process of the commodification of health care services began. The transformation of health services into private goods without regard for social benefits is a great danger in the framework of globalisation and neo-liberal policies.

Keywords: history of health service, dynamic of health services, public good, private good, commodity, commodification of health

INTRODUCTION

Health, defined as a state of total physical, mental and social well-being, is not individual, as is usually perceived, but is rather the result of economic and social life style factors. Just as it is not a product to be bought and sold, so it is impossible to value it in terms of use value. It is for this reason that the provision of health services must be special. The provision of health services is also the answer to the question of the kind of society we want in the future. The fundamental principle is the determination of needs according to specified aims and the meeting of these needs. However, not everyone who is in need can use health services. The use of health services is related to the ability to pay the cost of the service, willingness to pay, how long it takes to reach the health centre, and culture (WHO, 2000:35). This is why health services should not be focused on demand, but should be provided according to need (Starfield, 1998:17). However, the situation in which we have found ourselves in recent years is the commodification of the health service in Turkey and the provision of demand-oriented services, in line with worldwide trends. In Turkey, this situation has become even clearer over the last ten years. It is possible to summarise the situation by looking at some data.

While patient contact per capita in our country in 2002 was 1.1 for primary care and 2.0 for secondary and tertiary care with a total of 3.2, in 2011 this had risen to 3.3, 4.9 and 8.2 respectively (SB, 2012:85).

This increase in the use of services may be seen as positive, but it is important to question whether it has arisen due to those who were previously unable to use health services despite their needs starting to access the services, or whether it is due to supplier-induced demand.

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As of 2010, in comparison with other countries, the fact that the average patient contact for Turkey is higher than the averages for Sweden (2.9), the United States (3.9), Switzerland (4.0), Norway (5.2) and for the OECD countries (6.4) is evidence of supplier-induced demand (SB, 2012:86).

When we consider an international comparison of the number of MR machines in inpatient institutions per 1,000,000 population, it can be seen that in 2010, Turkey had more machines (10.5) than England (5.9) and France (7.0) (SB, 2002:72). This data indicates the excessive use of technology and waste. On the other hand, patient satisfaction has increased. When we consider general levels of satisfaction with health services, the proportion of those who were dissatisfied, which was 21.2% in 2003, had fallen to 12.2% in 2011 (SB, 2002:113). An increase in patient satisfaction while demand is also increasing indicates a successful marketing strategy. In 2012, when the economy of Turkey grew 2.2%, the third fastest growing sector was health and social services, with an increase of 5.3% (TÜİK, 2013:30).

The situation in which we find ourselves is the provision of health services which are focused on treatment, specialised, concentrated in the cities and emphasise technology. There have always been changes in the provision of health services. These changes reflect the political factors and realities of the era in which they occur.

In the present time, health services, which are open to market forces, are adapting in accordance with market rules. The process of the removal of obstacles to the workings of the market, such as the concept of public goods, information asymmetry and externality, has also been observed in health services. Among these obstacles, the concept of public goods has a more direct effect on the workings of the market and consequently, there have been changes related to the complete exclusion of health services from the concept of public goods.

Public goods from the perspective of health services

Public goods can be defined according to their properties. Individuals who do not pay for these goods cannot be excluded from their usage and the benefit that one individual gains from consumption of the goods does not reduce the availability of the goods to others. The benefits of these goods cannot be divided, there is no rivalry in their consumption and nobody can be excluded from their consumption. For example, when there is an outbreak of a disease, what needs to be done is to find the source of the outbreak and the means of transmission. The service given here comes within the scope of public goods. Healthy individuals will benefit as much from the investigation into the outbreak as those who have become sick. The fact that the whole society benefits from this service does not diminish the benefits to individuals; on the contrary, it increases the benefits. The discovery of the source of the outbreak and the removal of its means of transmission as a result of the investigation will prevent further outbreaks in the future. However, nobody will be willing to pay for an investigation into the outbreak of a disease. The sick will not want to pay because they are already sick, and the healthy will see it as an unnecessary expense because they are not sick. As a result, it can be envisaged that in the production of these goods, the market will be unsuccessful. While public goods are goods for which rivalry in consumption and exclusion from consumption are impossible, for private goods, both of these things are possible (Göker, 2008:114). It is not always possible to classify all goods and services as either public or private goods. There is some overlap between the two. These goods are known as club goods or common-pool resources.

For some goods and services, depending on circumstances, while exclusion from consumption may be possible, there is no rivalry; in other words, the use of the goods by one individual does not diminish their benefit to others. This type of goods are called club goods. In the present circumstances, this includes the health services which are included in the standard health coverage provided by the state to those who pay their social security premiums. With club goods, the interests of the individual are protected, rather than the interests of society. For this reason, it is natural that the standard health coverage provided by the state does not cover community-oriented health services. Those who do not pay their premiums cannot benefit from health services. It is easy for this type of goods to gain the status of private goods. The change in mentality which came about when health services began to be shaped by neoliberal policies has caused health services, which have for a long time had the characteristics of public or club goods, to gain the characteristics of private goods. Thus, in the new paradigm, a distinctive concept and organisation of health services has developed. When it was thought to be impossible to provide health services in the market, it was "easy" to define health as a right. When the conditions for commodification were generated, the concept of health as a right also began to be questioned. In Turkey, while health services continue to be dealt with in terms of preventive, curative and rehabilitative services, preventive services have been divided into individual and community preventive services. The reflection of the organisational model in primary care is that instead of health centres which consider all health services as part of a whole, primary care consists of units for individual preventive services, curative services and rehabilitative services, and separate units which only provide community preventive services. From another perspective, health centres have started to provide services with the characteristics of private goods, while former health centres have started to provide services

with the qualities of public goods. As the services begin to lose their characteristics of public goods, it may be envisioned that the distribution of duties between these centres will also change.

Common pool resources are goods for which there is no charge, but use by one individual diminishes their availability for use by other individuals. This includes the prerequisites for health of a clean environment and natural resources. Here, the state must ensure that those who do not use the resources are not harmed by those who overuse or misuse them. The environment must be protected by laws. Insufficient laws, or lack of enforcement, threaten our health. An example of this is the pollution of ground water resulting from prospecting for gold using cyanide.

At the present time, almost all health services have gained the attributes of private goods. The subject of this article is how changes in the concept of health services have developed throughout the course of history.

Antiquity

The search for immortality, and in one sense the search for health services, is as old as human history itself. The essence of one of the oldest works of literature, the Epic of Gilgamesh, is the search for health services. This tale, which tells the story of a person who is trying to discover the mysteries of nature, describes the first health service in history.

> *When Utnapishtim said to Gilgamesh, who was seeking immortality and looking at him with great curiosity, "Gilgamesh, you are very tired, sad and disappointed, I cannot bring myself to send you away empty handed. I am going to tell you one more secret of the Gods," Gilgamesh's heart started to beat quickly. He got his hopes up, thinking "Now he is going to tell me the secret of immortality!" Utnapishtim continued, saying "There is a plant with thorns. Just like the thorns of a rose, they prick your hands when you pick it and make them bleed. But those who eat this plant become young again and regain their old strength. However, this plant is to be found at the bottom of a deep lake on the road which you will travel. If you can take it out, you will regain your youth." When Gilgamesh heard the word youth instead of immortality, he was slightly perturbed, but still very pleased. Regaining his youth would at least extend his life. This was also very good.* (Çığ, 2000:74).

Over the years, the definition of health services has been shaped according to changes in the concept of health. In the times when human beings were hunter-gatherers who had to be constantly on the move, the only way to deal with disease was not to cure patients, but to let them die. Demand for health care services began when this idea was replaced by the healing of patients. In the years which followed, the search for and provision of health services continued in different geographical regions such as Mesopotamia, Egypt, India, China and Anatolia. In India, treatment included both mystic elements, herbal mixtures and methods resembling present day hospital services. Due to the fact that cutting off the nose was a punishment in their culture, the Indians became pioneers of plastic surgery in their operations to repair the resulting pathology.

According to the Mesopotamians, diseases were punishments for our sins. Disease was a punishment given to a person for a sin which they had committed. The treatment of disease was based on herbs, prayers, magic and metaphysical devices such as amulets. The laws known as the Babylonian Code of Hammurabi have the status of being the first laws to regulate the profession of medicine. These laws include subjects such as the law, medicine, punishment, family and commerce. Hammurabi ensured that these laws, written in the Akkadian language, were accepted as the word of God by saying that they had been dictated by the sun god Shamash. The Code of Hammurabi also included regulations regarding health services.

- If a surgeon has operated with the bronze lancet on a patrician for a serious injury, and has cured him, or has removed with a bronze lancet a cataract for a patrician, and has cured his eye, he shall take ten shekels of silver.
- If it be a plebeian, he shall take five shekels of silver.
- If it be a man's slave, the owner of the slave shall give two shekels of silver to the surgeon.
- If a surgeon has operated with the bronze lancet on a patrician for a serious injury, and has caused his death, or has removed a cataract for a patrician, with the bronze lancet, and has made him lose his eye, his hands shall be cut off.
- If the surgeon has treated a serious injury of a plebeian's slave, with the bronze lancet, and has caused his death, he shall render slave for slave.
- If he has removed a cataract with the bronze lancet, and made the slave lose his eye, he shall pay half his value.
- If a surgeon has cured the limb of a patrician, or has doctored a diseased bowel, the patient shall pay five shekels of silver to the surgeon.
- If he be a plebeian, he shall pay three shekels of silver.
- If he be a man's slave, the owner of the slave shall give two shekels of silver to the doctor.
- If a veterinary surgeon has treated an ox, or an ass, for a severe injury, and cured it, the owner of the ox, or the ass, shall pay the surgeon one-sixth of a shekel of silver, as his fee.

- If he has treated an ox, or an ass, for a severe injury, and caused it to die, he shall pay one-quarter of its value to the owner of the ox, or the ass.

Chinese medicine is also as much focused on preventing diseases as treating them, and is based on the principle of the individual existing in harmony with both himself and his environment.

The foundations of Chinese medicine are based on Yin and Yang, originating from the idea that everything is interconnected by forces of energy, the five elements, meridians or channels, collaterals and Chi theories. Even though it was ignored until the 1960s on the grounds that it would hinder the development of "scientific medicine", Chinese medicine still manages to retain its validity today.

In Egypt the first providers of health services were the priests, and this was followed by the formation of a class who only practiced medicine. This class was both controlled by the state and extremely active in social life. There was specialisation among doctors. The most important papyri found to date regarding Egyptian medicine are those of Kahun, Gardiner, Smith and Ebers. The Ebers papyrus contains detailed medical information and is known as the first handbook written as an essential reference for doctors to keep with them (Yoket, 2003:77).

The common feature of all these cultures was the prominence they gave to metaphysical devices. This situation is summarised in a saying which is written in the Ebers papyrus: "Magic is effective in conjuction with medicines. Medicines are effective in conjunction with magic." (reshafim.org.il)

Ancient Greece

It is widely accepted that the roots of our modern understanding of medicine go back to Ancient Greece, and that rational medicine began with Hippocrates. In Ancient Greece we can see the division of health services into preventive and curative services, under one roof. In Greek mythology, while Asclepius was the god of medicine and health, one of his five daughters, Hygieia, undertook the duties of protecting health whilst another daughter, Panacea, was responsible for healing. Thus, both preventive and curative services were combined in Asclepius. The perspective of Hippocrates, who was said to be the grandson of Asclepius, was similar. For Hippocrates, protection from diseases and the treatment of diseases were inseparable and he took a holistic view of health. The Hippocratic view, which was to form the foundations of western medicine, saw health as a result of environmental factors and lifestyle. A similar idea had been prevalent centuries earlier in Chinese medicine. Hippocrates is known as the father of modern medicine and is seen as the founder of rational medicine with his interrogative approach. After Hippocrates, the next significant physician was Galen of Pergamon. The influence of Hippocrates extended until times when Christianity saw Aristotle and Galen as divine. Galen was known by the church of the middle ages as Divine Galen: Divinus Galenus. The church ignored the interrogative aspect of Galen and turned his knowledge into a dogma. Many people who questioned the theories of Galen were burned at the stake (Straus and Stratus, 2009:39).

The Middle Ages

The provision of health services had been taken out of the hands of physicians and transferred to the clergy. In those times, the treatment fees were too high for the poor to pay. The majority of people could not afford medical treatment because of their poverty. In this period, when diseases were thought to be caused by an imbalance in the organism, the provision of health services was patient centred and gaining the trust of the patient was fundamental. In places where there were not any trained surgeons, barbers undertook this work. In the Middle Ages, scholastic medicine continued to play a role in increasing the strength of the church until the Renaissance. Books on medicine were translated into Arabic from the 7th to the 9th centuries. Using this knowledge, Islamic medicine made great contributions to the development of medicine. While Europe experienced bigotry in the Middle Ages, Islamic medicine developed with Ali Bin Abbas, Ibni Sina, Ebubekir Razi, Zahravi and Biruni. Placing importance on cleanliness in the prevention of disease, they looked after their patients in hospitals, which they called Darüşşifa, Bimaristan or Maristan. The plans of the hospitals founded in Europe after the Enlightenment were based on these hospitals. In this era, medical education in the West was in harmony with religious teachings. Trained physicians practised medicine according to the wishes of the clergy. For this reason, the practices of trained physicians were not always rational. The fact that physicians worked in the towns and palaces meant that those who lived outside the towns received their health services from people who had gained their medical knowledge through experience. However, these healers, who were counted as scholars in polytheistic times, became witches when the church wanted to cement its power. Witches were also shown to be the cause of all the socioeconomic woes of the time. This is because the church, which was against experiments, was afraid of them. Many witches came out against dogma with scientific methods. While these healers were well accepted by the general public, the physicians of the upper classes were those who had been through a formal education. Women were on the one hand accused of witchcraft and on the other hand excluded from medicine by being prevented from gaining formal education. The decision as to whether women accused of witchcraft were witches or not was left to the educated physicians. Thus, the reconciliation of the two different approaches to medicine was also prevented. This attitude came to an end with the Enlightenment. Secularism, rationalism and empiricism paved the way for

developments in medicine, just as they did for all the other sciences. At last, Europe started to advance, also making use of the progress Islamic medicine had made throughout the Middle Ages. Islamic medicine, meanwhile, had become less active. To summarise, throughout history until the 18th century, medicine and the provision of health services experienced swings between rational medicine and religious medicine. Those who benefited from the services were those who could access them. More often than not, health services were also used as an instrument of power. Both the supply of and demand for health services were limited. Until this time, health services were shaped not by the needs of people, but by their demands. A person seeking a cure for a disease could benefit from the service if they had the money. There was no demand for a health service aimed at preventing diseases. People did not even discern that they had such a need. It was not until the industrial revolution that this need for health services gave rise to the organised provision of health services.

Post Industrial Revolution

The problem of urbanisation, created by mechanisation, also brought with it various threats to health. While the physical conditions in the towns were a danger to health, long working hours caused a deterioration in the health of women and child labourers in particular. In some regions the average life expectancy fell to as low as 17 years. The main problems were poverty, an increasingly ruthless social structure, poor living conditions and increasingly common infectious diseases. The workforce became more and more unhealthy. While the economy developed, the health of the society deteriorated, and the life expectancy fell. In this period, it was believed that the majority of diseases were caused by breathing in air which had been infected by exposure to rotting matter. This matter could be rotting corpses, the breath of infected people, rubbish, or even rotting vegetables. "Miasmatic" theories about the causes of diseases lead to long debates among those who were responsible for fighting against the outbreaks of cholera which affected Great Britain, and London in particular, in 1831 and 1856. In the end, the British government, probably worried about the foundations of manufacturing, felt it necessary to take precautions. Edwin Chadwick was appointed by the government to produce a report on the health conditions of the working population. In this report, he made the connection between diseases and the poor living conditions in England. He stated that the poor were more often ill, died prematurely, and that there was a causative link between filth and diseases. He claimed that diseases could be prevented if the agents causing the filth were removed. After this report, the poor laws, factory laws and public health laws were passed. The Public Health Act 1848 brought the local administation of public health work and the encouragement of community participation to the agenda, and central and local health institutions were founded. The Public Health Act was the first of a succession of laws which showed that the state was responsible for the health of the general public. The government took on responsibility for something which it previously had not. The first organised health service had started to be provided. Improvements such as the construction of a system of sewers, the provision of safe water and the trend for toilets in middle class homes might have been partial, due to the fact that the laws did not cover everyone, and the division between the deserving and the undeserving poor based on the idea that the reason for poverty was individual and moral. However, even this partial improvement contributed to a rise in production and enabled the further strengthening of policies of colonisation with the aims of finding new raw materials and markets. The most important obstacle to Europe's expansionist policies was that during long sea voyages and due to unsanitary conditions abroad, the "white men" employed there became ill and died more often than had been expected. Accordingly, the provision of health services in the colonies began. The introduction of a more active policy of increasing the productivity of the colonies brought about the foundation of army health corps devoted to dealing with battles, schools of medicine and the London and Liverpool Schools of Tropical Medicine to fight against the diseases which were prevalent in these regions. Health services were provided in order to protect the health of Europeans to enable the expansion of colonisation, to keep African and Asian workers in working conditions which would not disrupt their work, and to prevent the spread of epidemics. However, it was not possible to talk about equality in health care provision. There were even differences in the use of health services between African and Asian workers. The health problems of the local people were ignored unless they were a threat to the Europeans, and in some regions the health service was limited to first aid.

War and the development of technology

The application to medicine of the scientific method, and the process triggered by Pasteur's 19th century identification of bacteria as agents of disease and the proposition of germ theory gave momentum to the development of medical science and technology. Tools such as thermometres, stethoscopes and endoscopes, vaccinations, anaesthetics, X-rays and antiseptics starting to become a part of medical practice. In this period giant hospitals were founded in central countries and patients became cases. Diseases rather than patients became the focus. This rapid development also led to the view of the human body as a machine and to the focus of health service provision being on disease rather than health. This paved the way for the provision of health services becoming dependent on technology. The first step towards dependence on technology was also the forerunner of the commodification of health services. The domination of the

biological paradigm led to the sense that health services were only comprised of curative services. Only a certain section of the population benefitted from curative services. There were no initiatives driven by the idea that everyone should benefit from the services. These were times when there was a concentration on the accumulation of capital. When the accumulation of capital reached a sufficient level, a new problem of sharing among countries emerged. The stage was set for the First World War. According to official statistics, this war, which was fought by 65 million soldiers from many countries, left behind a total of 8.5 million dead, 21 million wounded and 8 million missing in action or taken as prisoners of war. These were just the military losses. In various regions of the world, 20 million people lost their lives due to disease and famine resulting from the war.

The need for people to fight not against each other, but against hunger, poverty and diseases was made perfectly clear. After the First World War, it also began to be understood that from the perspective of human health, preventive medicine was superior to "treatment" and should come first (Fişek, 2013). However, there had not been a big enough loss of human life to affect production, and the need to develop health services had not arisen. Health services after the First World War became worse than they had been previously. On the other hand, the first public health service in the world was introduced in the former Soviet Union in the 1920s and started to develop rapidly. The vibrancy of the economies of other countries led them to scrutinise the model of the Soviet Union. This economic vibrancy and stability came to an end with the Great Depression in 1929. In the USA, Roosevelt started to implement a social and economic reform program: New Deal. Wages were increased, working hours reduced, unemployment benefit started to be paid and new job opportunities and public services were provided. Priority was given to public investments and services. However, there was no transition to a public health service. Meanwhile, the legacy of the First World War led to the outbreak of the Second World War, which has been described as the only way out of the Great Depression. With the United Nations Charter, the precursor of the United Nations organisation which was to be founded post-war in 1946, the countries fighting against Germany agreed to cooperate until the war was won. However, after the war had been won, this solidarity turned into the "Cold War". The increasing conflict between these powers was also reflected in health services. There had been over 70 million deaths due to the war. One task to be carried out in order to strengthen the countries of Europe which had undergone economic and social devastation and to enable them to withstand the ideological threat from the Soviet Union was the provision of a public health service.

The Welfare State

In 1941, while the war was going on, the Labour and Conservative Party coalition in Great Britain formed a committee. The job of this committee was to examine the existing social security system and to present recommendations. This report, known as the Beveridge Report, formed the basis of the social security and health systems. The report emphasised the foundation of the National Health Service, universal social security cover and the prevention of unemployment. The "National Health Service" took its inspiration from the health system initiated in the Soviet Union in the 1920s. An egalitarian, comprehensive provision of health services funded by taxes was recommended. However, for the establishment of this system, it was necessary for things to settle down after the war and for the Labour Party to come to power. On the one hand, the healthy workforce required to form the basis of production and on the other hand the Cold War period and the pressure from workers made it necessary to take steps to improve the health of the general public. With the coming to power of the Labour Party, the laws for the health system recommended by the Beveridge Report were passed in 1946-47 and 1948, and in 1948 the National Health Service (NHS) was founded. The health service, which was the beginning of the implementation of the welfare state, was to be provided to everyone free and on an equal basis by the state. The health system was to be funded by taxes and the proportion of services provided by the private sector was to be very small. This system, which was the solution produced by the capitalist world to counter the socialist type health systems, was known as the comprehensive health system or Beveridge Model. When this model was implemented in England, the health service produced gained the attributes of public goods. The upshot of this was that the conditions were right for the biological paradigm to start to be questioned. The health service was organised on the basis of need rather than demand. The intended population was not only those who could somehow pay for the service, but everyone who was in need.

Changes continued in the field of economics too. At the 1944 United Nations Money and Finance conference, the ground rules were set for economic activities and the decision was made to establish the World Bank and International Monetary Fund (IMF). These institutions came into operation in 1946 and in 1947 the General Agreement on Tariffs and Trade (GATT) act was passed in order to remove all obstacles to international trade and to put an end to discriminatory trade practices. The ecomomic recovery which started after 1940 had begun to spread to all countries by the year 1948. In 1948, the

World Health Organisation became the trailblazer of the biopsychosocial approach which was to dominate until the 1970s when it stated that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The WHO Constitution sees health as a social right and health services as public services, emphasising the social and economic determinants of health (Dedeoğlu, 2010:362). In this period, health services came under three headings: preventive, curative and rehabilitative. Within preventive services, there were two separate areas of individually-oriented and environmentally-oriented preventive health services. Individually-oriented health services included vaccination, nutrition, early diagnosis and treatment, family planning, the administration of medicine to prevent diseases (chemoprophylaxis), personal hygiene and health education, whereas environmentally-oriented health services were defined as what was necessary to create a positive environment, either by removing the biological, physical and chemical agents which were harmful to health, or by preventing people from being affected. This included the fight against microorganisms and vectors, plant and animal health, supply of trustworthy animal and vegetable foodstuffs, the provision of safe water and shelter, the disposal of wastes and the prevention of air and water pollution.

Globalisation

The concept of health services which had been generated by the biopsychosocial approach was structured into the concept of primary health care at the international conference held by the WHO in Alma-Ata in 1978. Primary health care (PHC) was defined as the effective provision of modern health services to everybody on an equal basis, at every stage, ensuring the participation of individuals and the community, in accordance with customs and requirements and using suitable technology. The health service provided had to include at least public education, promotion of food supply and the importance of nutrition, the provision of safe water and sanitation, maternal and child care including family planning, vaccination, the prevention and control of locally endemic diseases, the treatment of common diseases and injuries and the provision of essential medicines. These services as a whole were known as minimum care. The emphasis was on the provision of health services to everybody in need, whether well or ill, with the contribution of various professional groups, which prioritised prevention and were oriented towards biological, mental, social and economic disorders, and it was stated that the basis of health was the social, economical and physical environment of individuals. However, this pinnacle served in one respect as the beginning of the end. The fact that PHC was political rhetoric was the main reason why it did not become reality. Even though these years might look as if they were times when the principle of the social state was accepted in a bipolar world, they were years when the economy, which had been vibrant since the 1940s, began to stagnate with the crisis of 1970 and when the system collapsed with the announcement that the indexing of the dollar to gold had been abandoned. The repercussions of the crisis began to be seen in health services. Institutions which guide the world economy, such as the World Bank, implemented programs of "Structural Adjustment" in developing countries. The main prerequisites for these countries to be able to receive loans were the liberalisation of trade, the removal of state subsidies and price controls and cuts in social spending. In these circumstances, health services were also being restructured: the supply of the most cost-effective interventions for the poor and the provision of private health care for the rest of the population.

In 1993 the World Bank produced a report in collaboration with the World Health Organisation in which it announced which cost effective services would be included in the free coverage and how they would be measured. We became familiar with the concepts of burden of disease and DALY (disability-adjusted life years), a measure which represents the loss of the equivalent of one year of full health. DALY is a monetary expression of the burden of the incidence of disease, duration of disease, extent of disability caused by the disease, and years of full health lost due to the disease. If the DALY gained due to an initiative is less than the gross domestic product per capita, it is classed as highly cost-effective, if it is 1-3 times GDP per capita it is classed as cost-effective and if it falls outside these boundaries, it is classed as not cost-effective (who.int, 2013). Thus, countries were to generate service packages according to their incomes. The cost of those services which fell outside the scope of the package and gained the status of private goods was not to be met by the state. In 1995, the General Agreement on Tariffs and Trade (GATT), which provided the foundation of international trade, was transformed into the World Trade Organisation. It might have been thought that this liberalisation of trade had nothing to do with health services; however, the situation became clear when health and related services took their place among sectors expected to be opened up to the market in the General Agreement on Trade in Services (GATS). Communications, including telecommunications, postal services, visual and audial communication services, construction and related engineering services, education, systems of water supply, treatment of energy and waste water, all environmental services, accounting, finance and banking services, travel and tourism and the production of all products and services relating to these two sectors, cultural and sport services, land, air, sea and all other transportation services, and health and related services including social and other services were to be opened up to the market (Erol, 2013). All of these sectors are in fact related to health. The contribution of health services to determining health is no more than 20%, while

socioeconomic determinants such as education, employment, social support and security are twice as influential, and behavioural factors such as unsafe sex and the use of tobacco and alcohol have a 30% influence (icsi.org, 2013).

The Secretariat of the World Trade Organisation made the following statement about this agreement: "GATS not only covers trade and investment abroad, but is an "agreement on service investments and service trade", and covers all the sectors which are connected to the provision of a service, including the service and the production of goods." (Erol, 2013). This agreement is evidence not only that the service sector had opened up to the market, but also that health was no longer a right. Furthermore, once this agreement had been signed, there was no turning back. With the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs), an arrangement was produced in the medical technology sector, where inventions and patents are extremely important, which would benefit the developed countries which produced innovations and discovery and put developing countries at a disadvantage; the length of the patent protection was designated as 20 years from the date of application and therefore it became impossible to produce copies of medicines or vaccinations (Petrol-İş, 2013).

In a report published by the WHO, which had come under the direction of the World Bank, in 2000 (World Health Report 2000, Health Systems: Improving Performance), not only were the needs of patients replaced by the demands of customers, but it was stated that market share should form the basis of state planning and that it was necessary for enterprise to dominate public services (Navarro, 2000:1601).

DISCUSSION

Even though the conditions are suitable, the nature of health services has meant that at the present time, the commodification of all health services has not yet been possible. At present, health services can be classified as those which can or cannot be commodified. Those who cannot pay for services have been excluded from consumption.

Undoubtedly, there will now be efforts to create the conditions to enable the commodification of the health services which at present cannot be commodified. The extent to which the provision of health services has moved away from being public goods and become private goods will be the determiner of health systems in the years to come. Under present conditions, it is not difficult to spread the cost to the buyer, create demand, meet the demand with private sector supply and create competition among service providers. Individuals will be able to buy health services from the market "easily". However, the transformation of health services into private goods is a great danger due to the disregard for social benefits. Even though health services have been classified as private goods, the only way out is for citizens to show their preference for health services to be public goods using the mechanisms of democratic participation.

REFERENCES

Çığ MI (2000). Tarihte İlk Kral Kahraman Gilgameş. İstanbul:Kaynak Yayıncılık.

Dedeoğlu N (2010). Dünya Sağlık Örgütü, Sağlık Hakkı ve Küreselleşme. TAF. Prev. Med. Bull. 9 (4): 361-366.

Erol P (2013). Tüm Hizmetlerin Kapitalist Çevrime Dahil Edilmesi [http://www.ir.metu.edu.tr/conference/papers.html]

Fişek N (2013). Türkiye'de Sağlık Hizmetlerinin Geleceği [http://www.ttb.org.tr/n_fisek/kitap_1/23.html]

Göker Z (2008). Kamusal Mallar Tanımında Farklı Görüşler, Maliye Dergisi, 155 (2):108-118.

Navarro V (2000). Assessment of the World Health Report 2000. Lancet. 356: 1598–601.

Petrol-İş (2013).. Dünya'da ve Türkiye'de İlaç Sektörü [http://petrol-is.org.tr/sites/default/files/ilacsektoru-subat_2010.pdf]

reshafim.org.il. Pharaonic Egypt [http://www.reshafim.org.il/ad/egypt/timelines/topics/medicine.htm#rem19]

Starfield B (1998). Primary care: balancing health needs, services and technology. New York: Oxford University Press; 1998.

Straus A, Eugene W (2009). Tıbbi Mucizeler. İstanbul: Domingo Yayınevi.

Sağlık Bakanlığı TC (2012). Sağlık İstatistikleri Yıllığı 2011. Ankara: Semih Ofset Matbaacılık.

TÜİK (2013). Ekonomik göstergeler, Ankara: Türkiye İstatistik Kurumu Matbaası.

Who.int (2013). World Health Organization [http://www.who.int/choice/costs/CER_thresholds/en/]

WHO (2000). Equity in Access to Public Health - Report and Documentation of the Technical Discussions. WHO, New Delhi 2000.

Yoket Ü (2003). Eski Çağda Tıp. STED. 1(2):77-78.